Report to
The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

on

Supportive Housing as an Alternative to Psychiatric Hospitalization

Session Law 2010-152
Section 18.1

Task Force on Alternatives to Hospitalization
for Frequent Users of Psychiatric Hospitals in North Carolina

March 15, 2011

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
And Substance Abuse Services

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Executive Summary

This report has been prepared for the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services as required by North Carolina Session Law 2010-152.

The legislation instructs the North Carolina Department of Health and Human Services (DHHS) to conduct a study to determine the cost-effectiveness of supportive housing as an alternative to psychiatric hospitalization for individuals with mental illness, substance abuse or developmental disabilities. As required in the legislation, the Secretary of DHHS, Lanier Cansler, appointed two co-chairs and a task force to conduct the study and report to the General Assembly.

Summary of Key Findings and Conclusions

The Task Force identified approximately 1,700 individuals with mental health or substance abuse disorders or developmental disabilities in need of supportive housing. These individuals are homeless and cycle through State psychiatric hospitals, community hospitals, crisis services, jail and prison. Furthermore, their homelessness creates barriers to their taking advantage of housing and community mental health, developmental disabilities, and substance abuse services and supports. These individuals can be identified by local service providers.

The core value of supportive housing is for people with disabilities to have the right to live in the most integrated setting possible with accessible, individualized supports. Services and supports for individuals with mental health or substance abuse disorders or developmental disabilities are demonstrated to be more effective if the individual has a stable, safe place to live and adequate supports to remain in their home. Overall, supportive housing improves an individual's quality of life, self-direction, recovery, stability, and community inclusion.

Supportive housing is defined as decent, safe, and affordable community-based housing that provides tenants with all the rights of tenancy and services and supports that meets the tenant's needs and preferences. This includes both permanent and transitional supportive housing models.

Given North Carolina's success in the establishment of supportive housing over the last 18 years, the Task Force recognized the importance of building on the models that have worked to provide long term quality of life and cost savings over time.

Developing successful supportive housing must include capital, operating assistance, and access to services. This includes flexible funding to provide supports and services that are not "billable" such as training, tenancy supports, and other coordinating actions. Coordination of funding sources is complex and development is further complicated by

supportive services that are almost always disability specific and housing development and operating assistance that are almost always disability neutral.
An analysis of supportive housing costs for this group of people is based on existing programs and strategies to provide supportive housing units for 1,700 individuals over a period of three years. The analysis identifies potential cost offsets for the State concluding that implementation of such strategies would result in a cost neutral situation for the State, while ensuring greater potential for quality of life, stability and community inclusion for the persons served. Supportive housing is a good investment for North Carolina and its communities for these vulnerable residents.

Recommendations of the Task Force

This report builds the case for a statewide supportive housing plan that meets the needs of individuals with mental health or substance abuse disorders or developmental disabilities as an alternative to psychiatric hospitalization and that obtains maximum cost savings for the State of North Carolina as a whole. The Task Force submits the following recommendations and strongly suggests that the State take immediate action based on the strategies described below and in greater detail in the chapters of this report.

Recommendation 1. The Task Force recommends that the State provide permanent supportive housing for 1,700 individuals with mental health or substance abuse disorders or developmental disabilities who are homeless and frequent users of psychiatric hospitalization, crisis services, jail or prison. This will be accomplished by expanding existing housing programs and supportive programs that are successfully administered in North Carolina to create permanent homes and improved access to services and supports and to lay the ground work for a statewide system for moving from institutional care to integrated community care.

Strategy 1.1 Increase the State's ability to identify and qualify individuals for SSI/SSDI at the local level thereby increasing individual's income and access to Medicaid and reducing use of State resources, by funding 26 dedicated SSI/SSDI Outreach, Access and Recovery (SOAR) positions with one at each of the 23 LMEs and each of the three State psychiatric hospitals at an estimated cost of $1,950,000.

Strategy 1.2 Support the enrollment of potential Medicaid recipients prior to January 2014 to increase access to current benefits.

Strategy 1.3 Support the partnership of DHHS and the North Carolina Housing Finance Agency (NCHFA) to provide 1,700 additional supportive housing units as follows:

- Increase funding by $2,709,000 for the DHHS Operating Subsidy to continue the Key Program Target Units for both the Housing Credit ($2,128,500) and Supported Housing Deposit Program (SHDP) ($562,500) and allow costs for up to 7.5% of funding.

- Expand funding of $3,775,464 through DHHS Operating Subsidy to create a Tenant Based Rental Assistance Program and allow administrative costs for up to 10% of funding.
- Expand funding of $1,012,500 through DHHS Operating Subsidy to create a Deposit Program to allow for up-front rental and utility deposits to be paid reducing a primary barrier in obtaining housing.
- Expand Oxford Houses Partnership Program by funding it with a one-time addition of $200,000 to the revolving loan program and 15 positions at an estimated cost of $1,125,000.
- Increase funding by $18,900,000 for the Housing Trust Fund.

Recommendation 2. The Task Force recommends implementation of these expanded housing and supportive programs over a period of three years through 10 pilot programs across the State in a variety of communities.

Strategy 2.1 Fund $2,500,000 to provide flexible funding to the pilot projects to customize necessary services and supports to ensure individuals have transition services they need, maintain access to their individual service providers, and are provided tenancy supports as needed. This includes the provision of Assertive Engagement and 24/7 support needed during the transition period from institution or homelessness to supportive housing.

Strategy 2.2 Ensure staff of supportive housing programs and service providers receive training on tenancy supports, including landlord and employer relationships.

Strategy 2.3 Work to eliminate barriers to access for housing and employment for individuals with mental health or substance abuse disorders leaving prison or jail.

Strategy 2.4 Promote wraparound services through a system of care approach to facilitate the transition of individuals discharged from institutions to the community services.

Recommendation 3. The Task Force recommends strengthening the State's capacity to implement, oversee and evaluate the effectiveness of permanent supportive housing, services and supports on the quality of life of program participants.

Strategy 3.1 The Practice Improvement Collaborative (PIC) review and recommend models of services and supports that are evidence based or emerging best practice for individuals with mental health or substance abuse disorders and who are homeless.

Strategy 3.2 DHHS consider asking the North Carolina Interagency Council for Coordinating Homeless Programs (ICCHP) to advise and review the work of all participating agencies as these agencies promote supportive housing for individuals with mental health or substance abuse disorders or developmental disabilities in all areas of the State, investigate best practices, sponsor pilot projects, provide oversight, conduct performance evaluation and secure funding and technical assistance for local supportive housing projects.

Strategy 3.3 DHHS develop a clearinghouse of housing resources across the State in the Office of Housing and Homelessness by expanding the NCHousingSearch.org tool. This strategy increases the State's ability to track and access supportive housing for all disabilities and special needs by funding NCHousingSeach.org and a dedicated position within the DHHS Office of Housing and Homelessness to administer access to restricted areas and to train housing and service providers on its use at an estimated cost of $275,000.

Strategy 3.4 Fund one position within the DHHS Office of Housing and Homelessness that is responsible for tracking program participants to ensuring they receive housing and service resources necessary for remaining in the community and for evaluating the success of the pilot programs in terms of improving the quality of life, enhanced effectiveness of services provided, and the cost effectiveness of providing housing, tenancy and SOAR services at an estimated cost of $75,000.

Strategy 3.5 Ensure coordination among LMEs, service providers, housing, and Community Care of North Carolina to assure physical healthcare access for program participants.

Strategy 3.6 Provide technical assistance to communities statewide for leveraging funding and accessing resources available to develop and finance supportive housing options locally.

Strategy 3.7 Develop coordination among information technology systems that supports sharing of information and tracking individuals across systems and services including Medicaid, IPRS, HEARTS, CCNC, CHIN, prisons and jails, and enables LMEs to coordinate care and maximize the use of limited funds.

Clearly, this is the time and opportunity to take action to continue North Carolina's success and leadership in responding to individuals with mental health or substance abuse disorders or developmental disabilities and who are homeless through the provision of permanent supportive housing. Although the costs and cost offsets of these strategies will involve some ongoing funding each year, these costs can be minimized by increasing the eligibility of these individuals' entitlement to Medicaid and Supplemental Security Income and by vastly improving their quality of life. The recommendations and strategies will enable the State to provide permanent supportive housing for 1,700 individuals with mental health or substance abuse disorders or developmental disabilities and relieve the State of crisis services for that high cost group of people.

Chapter 1. What is Supportive Housing?

This report has been prepared for the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services as required by North Carolina Session Law 2010-152.

Summary of Legislation and Study Goals

Session Law 2010-0152 instructs the North Carolina Department of Health and Human Services (DHHS) to conduct a study to determine the cost-effectiveness of supportive housing as an alternative to psychiatric hospitalization for individuals with mental illness, substance abuse or developmental disabilities. As required in the legislation, the Secretary of DHHS, Lanier Cansler, appointed two co-chairs and a task force including representatives of:

- NC Department of Health and Human Services (DHHS).
- Housing Trust Fund.
- Local Management Entities (LME).
- Department of Correction (DOC).
- Division of Medical Assistance (DMA).
- Private providers of housing services.
- Public housing agencies.
- Consumers and family members.

The legislation instructs the Task Force to propose a plan for individuals with mental health or substance abuse issues or developmental disabilities that addresses goals of the public mental health, developmental disabilities and substance abuse services system including:

- Developing cost effective system of care.
- Decreasing the need for hospitalization.
- Decreasing the length of stay in hospitals.
- Decreasing the rate of incarceration and reducing recidivism.
- Decreasing emergency room use and improving consumer functioning.
- Decreasing homelessness.
- Maintaining consumers in the community and making communities safer for consumers/others.
- Exploring funding possibilities from Medicaid/other sources.

The legislation further instructs the Task Force to:

1) Identify frequent users of State and community psychiatric hospitals and emergency departments and to determine for these users:
    - Their housing situation
    - Incarceration history
    - Recidivism rates

- Treatment offered and treatment compliance
- Other factors determined by the task force

2) Review existing State and national initiatives, and
3) Use this information to:
    - Study current practices/issues regarding placement of individuals after discharge from psychiatric facilities.
    - Develop a business case for the development of statewide supportive housing initiative.
    - Calculate number of housing units needed statewide.
    - Calculate the level of capital investment needed for multi-year initiative.
    - Propose different methods that could be used to pay ongoing operational costs.
    - Examine potential cost-savings.

The term "supportive housing" has historically been used in a variety of ways generally meaning the combination of affordable housing and services as a means to support recovery through the effective use of treatment for individuals with mental illness, substance abuse or developmental disabilities, and to promote stability in the community.

Multiple models and funding streams of supportive housing have been established in North Carolina and across the country that are applicable for particular populations. The Task Force examined a number of these as described in chapters 3 and 4. Both permanent supportive housing and transitional housing were analyzed as defined below.

Definition of Permanent Supportive Housing

At the federal level, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) promotes Permanent Supportive Housing (PSH) as an evidence-based practice.[1]

SAMHSA was established in 1992 by Congress to provide national leadership in policy and practice regarding effective services and treatment for persons with substance abuse and mental disorders. Over the years, SAMHSA has demonstrated that prevention works, treatment is effective and people recover from mental and substance use disorders.

One of SAMHSA's eight national strategic objectives is Housing and Homelessness.[2] The goals of this strategic initiative are:

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[1] Evidence based practices are services that have consistently demonstrated their *effectiveness* in helping people with mental illnesses, substance abuse and other disabilities to achieve their desired goals. Effectiveness was established by different people who conducted rigorous studies and obtained similar outcomes.

[2] See www.samhsa.org.

- **Prevent homelessness among individuals with mental and substance use disorders.**
- **Create permanent stable housing for behavioral health populations.**
- **Implement supportive housing services.**

Through this initiative, SAMHSA serves as the lead federal agency for promoting and increasing Permanent Supportive Housing practices for the most vulnerable individuals and families who are homeless or at risk of homelessness. To promote the use of evidence-based practices, in 2010 SAMHSA developed a toolkit for Permanent Supportive Housing that focuses on supporting communities with resources to implement a scattered site model of supportive housing.

In addition to SAMHSA, since 2003 the U.S. Interagency Council on Homelessness (ICH), a council of over 20 federal agencies, has worked with local communities to identify effective strategies for ending homelessness. The ICH has stressed that permanent supportive housing not only improves quality of life, but is cost effective for communities in both direct fiscal impact (e.g. services dollars saved) and indirect fiscal impact (e.g. improved business district atmosphere).

The Task Force has elected to adopt SAMHSA's definition of Permanent Supportive Housing, which is:

> *"Decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under State and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences."*

SAMHSA elaborates on this evidence-based practice as a means to make housing affordable to someone on Supplemental Security Income (SSI), either through rental assistance alone or in conjunction with housing development. It provides sufficient wraparound supports to allow people with significant support needs to remain in the housing they have chosen.

Definition of Transitional Supportive Housing

Transitional housing is usually thought of as temporary supported housing; that is housing with services where individuals or families live during the time they receive intensive stabilization services that prepare the household for independent living.[3] The Task Force recognizes that transitional housing is not needed for every consumer, and recommends that, in the vast majority of cases, transitional housing not exceed six

[3] North Carolina Housing Coalition, *Glossary of Housing Terms*. Retrieved from: http://www.nchousing.org/advocacy-1/messaging-strategy/nchc-housing-comm-manual/Glossary%20of%20Terms.pdf

months. A limited transitional phase allows for adequate medical stabilization but also improves outcomes in an individual's transition to permanent housing arrangements.

Definition of Recovery

Recovery: The primary goal of supportive housing as defined by the New Freedom Commission on Mental Health:[4]

- A process by which people are able to live, work, learn, and participate fully in their communities.
- The ability to live a fulfilling and productive life despite a disability.
- Reduction or complete remission of disability or distressing symptoms.

Fundamental aspects of recovery are *self-direction, individualized and person-centered, empowerment, strengths-based, peer support, respect, responsibility and hope*.[5] The following core elements of supportive housing enable individuals to achieve and sustain tenancy – a key element in recovery.

Consumer Choice: Individuals should be free to choose housing from the same living environments that are available to the general public.

Separation of Housing and Services: Participation in a menu of specific support services is readily available, but not required to get or keep housing.

Decent, Safe and Affordable: Tenants should pay no more than a reasonable amount, or 30%, of their income toward rent and utilities as based on HUD affordability guidelines.

Community Integration: Integrated housing is in residential areas. Community integration is based on principles of fair housing including the value of diversity with mixed populations in buildings and/or neighborhoods to avoid creating segregation and isolation and to promote recovery. Tenants are encouraged to participate in community activities to develop natural supports and receive community services.

Rights of Tenancy: Tenants have full legal rights in a tenant-landlord relationship and must abide by normal requirements of conduct outlined in a lease.

[4] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*

[5] December 2004 Consensus Conference on Mental Health Recovery, sponsored by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration

Access to Housing: Access to housing should be restricted to those elements required of any tenant, for example, ability to pay rent and not on participation in services.

Flexible, Voluntary Recovery-Focused Services: Tenants can accept or refuse treatment or other services, while staff demonstrate best practice by continuing to offer support and use flexible assertive engagement strategies. The type, location, intensity, and frequency of services must adjust to meet tenants' changing needs. Recovery oriented, consumer driven and evidence based services work best.

The Supportive Housing Continuum

An example of the process that might be used to support a person in securing permanent supportive housing is shown in figure 1. A person may enter at any point along this continuum.

This is built on a foundation of Assertive Engagement, a practice defined as a way of working with adults and/or children who have severe or serious mental illness or substance abuse and who do not effectively engage with treatment services. Assertive Engagement is a critical element of the rehabilitation and recovery model as it allows flexibility in meeting a person's particular needs in his or her own environment or current location (i.e. hospital, jail, streets, etc.). For example, preparation would occur for a person who is in a psychiatric hospital or prison to plan for re-entering the community in the way that best offers opportunities for long term stability. Some may need intensive transitional services for medical stabilization in an interim setting. Or a homeless person may move directly into permanent housing with individualized transitional and permanent services. In any case, the continuum is used to illustrate the overall process and different ways to meet an individual's needs.

Figure 1. A Continuum of Supportive Housing

Preparation	Transitional Steps	Permanent Supportive Housing
Assertive Engagement prior to discharge from hospital, prison, jail or homeless shelter.	1 week - 6 months Respite plus medication management; connection to clinical home, access to a psychiatrist and behavioral health care; medical stabilization Transitional housing with intensive services, supports & skill building including 24/7 help center.	Move to permanent supportive housing with wraparound services, peer support, natural supports and skill building and 24/7 help center; connection to clinical home as needed.

In summary, the core value of supportive housing is:

> *People with disabilities have the right to live in the most integrated setting possible with accessible, individualized supports. Supportive housing results in improved quality of life for individuals and direct and indirect cost benefits for the community.*

Chapter 2. Who are the Anticipated Program Participants?

The legislation requires the Task Force to identify frequent users of State and community psychiatric hospitals and emergency departments and to determine for these users:

- Their housing situation.
- Incarceration history.
- Recidivism rates.
- Treatment offered and treatment compliance.
- Other factors determined by the Task Force.

The Task Force examined readily available data from multiple sources including:

- Division of State Operated Healthcare Facilities (DSOHF) - Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS) from the State psychiatric hospitals.
- Division of Mental Health, Developmental Disabilities and Substance Abuse Services – Client Data Warehouse, Integrated Payment and Reporting System (IPRS), NC Treatment Outcomes and Program Performance System (NC-TOPPS), the Community Systems Progress Report, Consumer Survey.
- DHHS – 2009 NC Consolidated Annual Action Plan.
- Local Management Entities (LMEs) – survey of housing needs.
- National studies regarding housing.
- NC Coalition to End Homelessness.
- Previous studies and reports.

Use of State Psychiatric Hospitals

Of the individuals admitted to the State psychiatric hospitals in State fiscal year 2009-2010, prior living arrangements were documented in the HEARTS database as follows:[6]

- 69% lived in private residences
- 1% lived independently (in a rooming house)
- 8% were homeless
- 6% were in a correctional facility
- 8% were in another institution (psychiatric hospital, MR center)
- 4% were in a residential facility (nursing home)

[6] SOURCE: From the DMHDDSAS and DSOHF Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS) database.

- 4% were dependent (a child living with foster family)

Discharge information is also recorded in the HEARTS database indicating the destination of the 6,601 individuals discharged during SFY2009-2010 as shown in table 1. Importantly, the places where individuals are anticipated to live after discharge (including private residences) are not always where they actually reside over time, and a short stay with family might quickly turn into a homeless episode. Twelve percent of discharge referrals from the State psychiatric hospitals were to homeless shelters, hotels or correctional facilities. Taken together these indicate a group of 816 individuals that are likely to become homeless and can be identified as needing immediate focus on their housing needs.

Table 1. Expected Destination of those Discharged from State Psychiatric Hospitals

Destination	Totals	% of All Discharges
Alcohol/Drug Abuse Treat Center	422	6%
Supervised Apartment Living	12	0%
Correctional Facility	425	6%
Alternative Family Living	30	0%
Family Care Home	179	3%
Group Home - CAP/MR	3	0%
Group Home - DDA	5	0%
Group Home - ICF/MR	0	0%
Group Home	500	8%
Halfway House	199	3%
Homeless Shelter	342	5%
Hotel	49	1%
Other Independent	46	1%
Private Residence	4088	62%
Rest Home	95	1%
Supported Living	206	3%
Total (all discharge destinations)	6601	

Information from the DMHDDSAS Client Data Warehouse (CDW) shows in Table 2 the prior living arrangement of individuals admitted to the State operated psychiatric hospitals in SFY 2009-2010.

Table 2. FY2010 Psychiatric Hospital Admissions by Living Arrangement

Admissions Living Arrangement	Admissions	%
Private residence	4,727	74.4%
Homeless(street, vehicle, shelter for homeless)	514	8.1%
Correctional facility(prison jail training school	343	5.4%
Foster family alternative family living	248	3.9%
Institution(psychiatric hospital mental retardation	242	3.8%
Residential facility excluding nursing homes(halfway house)	232	3.7%
Other independent (rooming house dormitory barrack)	49	0.8%
Total	**6,355**	

Further, data from the CDW shows in Table 3 the referral of individuals discharged from the State psychiatric hospitals during the same SFY2009-2010.[7]

Table 3. CDW FY2010 State Psychiatric Hospital Discharges

Discharge Referral	Number of Discharges	%
Other outpatient and residential non State facility	5,268	82.2%
Unknown	399	6.2%
State facility	341	5.3%
Other	187	2.9%
Family friends	113	1.8%
Other health care	50	0.8%
Court corrections prisons	16	0.2%
Psychiatric service General Hospital	13	0.2%
Veteran's admin.	9	0.1%
Private physician	4	0.1%
Community agency	2	0.0%
Self/no referral	2	0.0%
Nursing home board and care	1	0.0%
	6,405	

Transition to the Community

DHHS is aware that although plans call for stable places for individuals following discharge from a State psychiatric hospital, circumstances can result in individuals moving to less stable environments. For example, the plan might call for a person living with a parent, and yet circumstances prevent the person being able to remain in that setting. The Department recognizes this as an issue and has put efforts in place to enhance and support LMEs as they endeavor to improve the stability of such situations.

One such effort involves DMHDDSAS tracking the progress of LMEs on established statewide performance measures in its quarterly *Community Systems Progress Report*.[8] Three of those measures focus on the use and coordination of services between LMEs and State psychiatric hospitals.

> Timely Follow-Up After Inpatient Care (April-June 2010): Statewide, 53 percent of consumers discharged from a State psychiatric hospital were seen within seven days following discharge this quarter. This is an improvement over April-June 2008 when only 35 percent of persons discharged from a State psychiatric

[7] Admissions and discharge information in HEARTS is usually higher than CDW for any given timeframe because HEARTS is a billing system that also includes transfers within wards of the same facility therefore creating admissions and discharges. Within CDW admission and discharge information is collected only when a person enters and leaves the facility. Transfer information is not collected in CDW when a person is moving within the facility or is on temporary leave from a facility and comes back.
[8] See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

hospital were seen within seven days. The Division's SFY 2010 statewide goal for follow-up care is 70 percent of consumers seen within seven days following discharge.

State Psychiatric Hospitals Readmissions (April-June 2010): Statewide, seven percent of consumers discharged from a State psychiatric hospital were readmitted within 30 days. The SFY 2010 statewide goal is 10 percent or less. Across the State, 18 percent of consumers were readmitted within 180 days. The SFY 2010 statewide goal is 22 percent or less.

Effective Use of State Psychiatric Hospitals (April-June 2010): With a statewide goal to reduce use of State psychiatric hospitals for short term care (seven days or less), 34 percent of consumers in State hospitals had stays of seven days or less. The SFY 2010 statewide goal was no more than 44 percent of consumers representing continued improvement from last quarter.

Psychiatric hospital social workers and LME Hospital Liaisons, frequently call on the expertise of LME Housing Specialists to help them identify housing options for persons without readily apparent discharge options. Housing Specialists have knowledge of housing options within their own catchment area, but there is not a State mechanism in place to assist with placements across LME or county lines, or to identify and minimize additional barriers that become significant when crossing those borders. NCHousing Search, discussed in greater detail in Chapter 3, offers a technology that could assist with this need.

Use of Community Services

During State fiscal year 2009-2010, a total of 332,796 persons were admitted to community services through local management entities (LMEs).[9] This figure represents adults and children and includes all three disabilities – mental health, substance abuse and developmental disabilities.

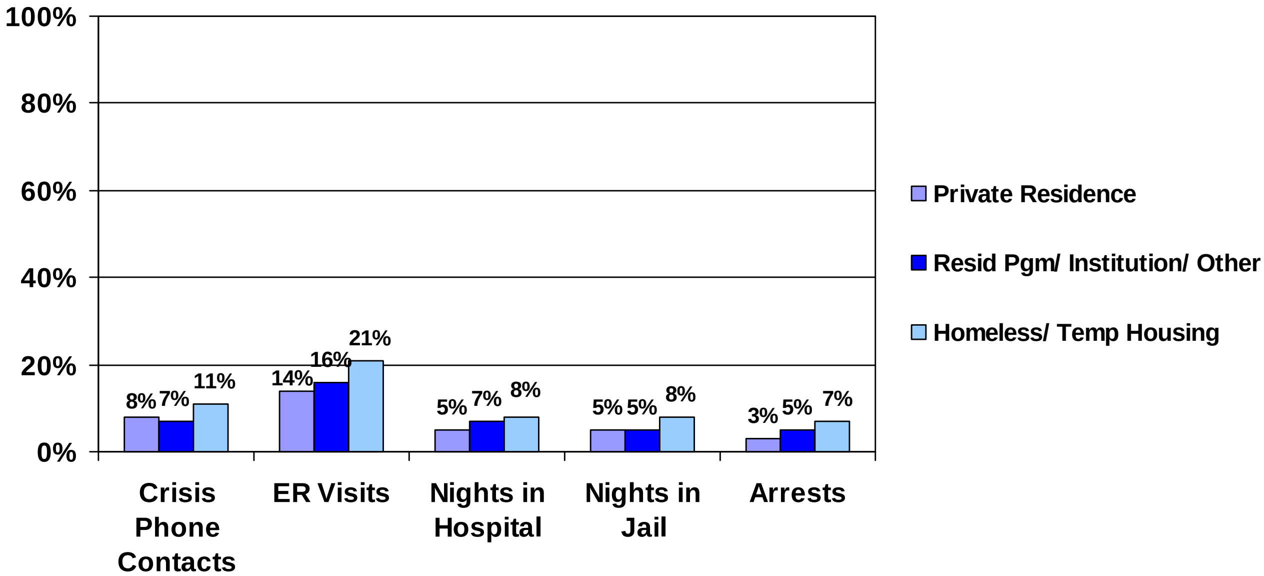
Of these, 267,000 were adults, of whom 85 percent were living in private residences and five percent were homeless at admission to community services. It is important to note that of those reporting to live in a private residence, some may be staying temporarily with family or friends. This is not considered permanent housing.

At their most recent update of NC-TOPPS,[10] adult consumers who did not live in a private residence upon admission reported (1) their current living arrangement and (2) their experiences during the last three months with crisis services, emergency room visits,

[9] Data is from the Division's Client Data Warehouse.
[10] Data is from the Division's NC Treatment Outcomes and Program Performance System (NC-TOPPS).

night in a hospital or jail and arrests.[11] As seen in chart 1, consumers who still report being homeless or in temporary housing access these costly crisis services more frequently.

Chart 1. Experiences during the most recent three months of treatment of adults who did not live in a private residence upon entering treatment.



Use of Community Crisis Services

DHHS believes that keeping people close to home when a crisis occurs is an important ingredient to reintegration into the community. Continuity of housing supports the effectiveness of treatment, and many experts consider stable housing a therapeutic intervention in and of itself. Once settled in a stable living situation, individuals can engage in a variety of services and treatments available to them, including crisis services when needed.

Since 2008, with the support of the General Assembly, crisis services have developed statewide with the intention to provide services close to where an individual lives, thus reducing the use of State psychiatric hospitals for short term stays. The community crisis services include walk-in crisis and psychiatric aftercare clinics, mobile crisis teams, contracts with community hospitals for psychiatric beds, and NC START teams and respite beds. Although data about living arrangements and housing are not available, crisis services data do indicate the demand for supportive housing.

[11] SOURCE: NC-TOPPS initial interviews of adults with mental health and/or substance abuse diagnosis in CY 2009 matched to most recent update interview that occurred either at three months after admission or each six months thereafter.

For example, during January-June 2010, 66 walk-in crisis and psychiatric aftercare clinics across the State reported:

- 110,296 individuals were served.
- 3.7 percent (4,081 individuals) were referred from a State facility, community hospital psychiatric service or emergency department to the walk-in center.
- 1.1 percent (1,213 individuals) were referred by the walk-in center to a State facility or community hospital psychiatric service.

The Division of MH/DD/SAS provides a quarterly report to LMEs on the use of community hospital emergency departments by residents in each LME's catchment areas.

- During January-March 2010, a total of 1,026,993 emergency department admissions were reported by 111 of the 112 community hospitals in the State.
- Of these, 33,211 (3.2%) admissions had a primary diagnosis of a mental health, developmental disabilities, or substance abuse disorder.
- Disposition data for admissions with a primary or co-occurring MH/DD/SA diagnosis:
    - Almost three-fifths (58.3%) of admissions were discharged from the emergency department.
    - One-third (32.9%) of admissions were admitted to a hospital (ICU, Psych Unit, or general admission)
    - 5.7% were transferred.
    - 3.1% had another disposition (e.g. left AMA or without advice).

Use of Jails

A study was conducted in 2006 to determine the current procedures in North Carolina county and regional jails regarding individuals with mental illness (MI) or mental retardation/developmental disability (MR/DD).[12] Some highlights of the results are listed here.

- Jails in North Carolina are stressed, on average at 107 percent of capacity.
- Jailers expressed concern about staffing and fiscal demands when housing individuals with mental illness, particularly concerning medications.
- Handling emergencies is difficult for jails. Transfer of inmates to Central Prison Safekeeping or to a State psychiatric hospital is the usual strategy – often a lengthy process involving considerable jail staff time – and not a clinical best practice.
- Communication between jail and community care is erratic. For example, 60 percent of jails report contacting the provider at admission, but only 19 percent report always contacting provider at release and only 9 percent of jails report always being contacted by community provider when a consumer is in jail. A majority (61 percent) of inmates reported that they were not allowed to contact their provider while in jail. In general, Medicaid does not pay for services to be delivered in jail. There are

[12] Vaughn, J. and A. Scheyett, *Identification and Treatment of Individuals with Mental Illness or Mental Retardation/Developmental Disability in North Carolina Jails*, 2007.

federal and State funds to provide jail diversion services (that is to arrange for services outside the jail) depending on availability of the program locally.

The report provided the following recommendations including:

- Adopt use of evidence-based screening tools to identify individuals with mental illness, mental retardation, or developmental disabilities, and those at risk of suicide, and ensure that jail staff has ongoing training to work with these individuals.
- Jails and LMEs need quick and frequent communication, including information to the jail about the inmates' prior community-based treatment and medications, as well as any other relevant information that would help jail staff with the individual while incarcerated and information about date of inmate release to the LME.
- Inmates should be released with a timely appointment made with a community provider.

Some things have changed for the better since that report, as some of the recommendations have been implemented. One change is that the LMEs now must check the daily booking logs at local jails to help identify known mental health consumers who may need treatment while in jail. However, LMEs don't report information about inmates to the State. Therefore, the Division does not have aggregate data on individuals discharged from jails or their discharge destination. One reason is that many people rotate in and out of jail very rapidly, while the prison population tends to be more stable with much less turnover.

Use of Prisons

In the year ending June 30, 2010, 27,371 individual inmates were released from North Carolina prisons and approximately one-quarter (25.5 percent) of these had at least one diagnosis for a mental health disorder. Nearly two-thirds (65.8 percent) of inmates with a mental health diagnosis (6,977 inmates) also had a prior period of incarceration. Substance abuse disorders were the most frequent (44.6 percent) followed by personality disorders (20 percent) and mood disorders (14.7 percent). Relatively few (12.6 percent) of the diagnoses were for disorders considered serious mental illnesses (SMI).[13]

In the year ending August 31, 2010, 28,736 inmates were discharged from prison. Upon entering prison and thereafter, inmates are triaged into one of five mental health grades reflecting an inmate's need for mental health treatment. It is important to note that the North Carolina Department of Corrections (DOC) does not count substance abuse disorders for purposes of prison mental health statistics, so substance abuse is not included in these statistics.

Of the inmates discharged DOC estimates:

[13] NC DOC, Office of Research & Planning, Statistics request DP11-10.01.

- 2,827 were classified as needing both psychological and psychiatric services but were not considered currently unstable.
- 227 require residential housing due to chronic mental illness that precludes placement in a general population setting.
- 108 require inpatient mental health treatment.

Note that mental health social workers are mandated by policy to have discharge planning for mental health inmates in place no less than 30 days prior to any release whether to the community or possibly to a state hospital.

In a recent investigative study[14] of the psychiatric and criminal histories of consecutive admissions (n=342) over a five month period to a pre-trial evaluation program established for persons accused of a crime and thought to have a mental illness, the data revealed that 286 (83.6%) had experienced prior contact with one or both systems; 92 (26.9%) had been in prison, 48 (14.0%) had been in a state psychiatric hospital, while 146 (42.7%) had been in both systems.

The authors of the study referenced above note that while the number of state hospital psychiatric beds in the United States has declined over the past few decades, the number of persons with a mental illness being treated in prison has increased. Of concern is that difficulty of transitions from the prison or state hospitals back into the community results in a high number of persons who cycle between our nation's prisons and state psychiatric facilities.

The Homeless in North Carolina

As reported by the North Carolina Coalition to End Homelessness, communities across the State participate in the Point-in-Time Count of who is homeless on a given night as a snapshot of homelessness (not an unduplicated count of everyone homeless over the course of a year). On January 27, 2010, the North Carolina Point-in-Time Count determined the number of homeless individuals throughout the State.[15] Below are partial results from that count related to individuals as possible participants in supportive housing.

[14] Jones, N., Carbone, J.S. et al., "Psychiatric and Criminal Histories of Persons Referred for Pretrial Evaluations: Description and Policy Implications." Pending publication in the Journal of Forensic Psychiatry and Psychology.

[15] Any community using HUD Continuum of Care funding must do a Point-In-Time count the last week of January.

Table 4. North Carolina Point-In-Time Count on January 27, 2010

	Emergency Shelter	Transitional Shelter	Unsheltered	TOTAL Homeless Individuals
# Households with dependent children	501	618	185	
Total individuals	1,457	1,859	549	3,865
# Households without dependent children	3,510	2,250	2,449	
Total individuals	3,528	2,295	2,469	8,292
Total homeless (adults only)	**4,079**	**2,989**	**2,660**	**9,728**
SUBPOPULATIONS (# of total homeless adults only)				
Chronic homeless (have a disability & have been homeless 1 yr or 4 episodes in 3 years	1077	436	402	**1,479**
Seriously mentally ill	580	484	300	1,364
Diagnosable substance use disorder	950	1,523	459	2,932
Discharged within 30 days prior to becoming homeless:				
From jail or prison	210	208	165	583
From psychiatric hospital or substance abuse treatment	167	365	64	596

Summary

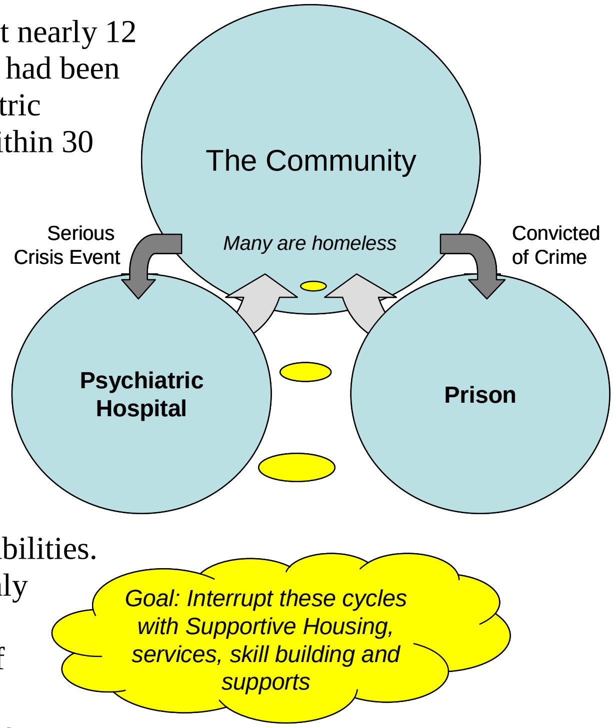
Overall, the Task Force found that significant barriers exist in data systems across State government and across communities due to the lack of interconnectivity among systems. While information may be available within a specific system, it is not possible to track individuals across State hospitals, community hospitals, prison systems, and homeless programs. In addition, access to data in private hospitals is very limited and information about housing or living situations is usually not recorded. Data systems remain in "silos" and often definitions of the populations served in the various systems differ widely. Consequently, the Task Force could not readily link the incarceration history, use of State psychiatric hospitals or use of community hospitals for any one individual without conducting an in-depth study.

Regardless of the data challenges, there appear to be consistent indicators and patterns that allow us to better understand the individuals that frequently are in jail/prison and use State psychiatric facilities and crisis services.

- While over 82 percent of discharges are referred for outpatient treatment, seven percent are readmitted within three months and 18 percent were readmitted within six months.

- Individuals who are homeless have higher rates of crisis services, arrests, and hospital stays than those who are not homeless.

- In the most recent Point in Time count nearly 12 percent (1,179) of all homeless adults had been discharged from prison/jail, a psychiatric hospital or substance abuse facility within 30 days prior to becoming homeless.



- Income is a significant contributing factor to the housing instability that defines this population. Persons with mental illness have a particularly difficult time navigating the disability application process, resulting in a lower approval rate for homeless persons with mental illness than homeless persons with other disabilities. Successful applicants receive a monthly income of only $674 (2011 payment standard). Given HUD's definition of affordability, these persons can only afford to pay $202 for rent and utilities.

- There is a group of individuals who enter psychiatric hospitals from homelessness and prison/jails and who are discharged to the same locations. While the data does not allow us to determine whether these are the same individuals, the numbers are comparable and these are individuals who can be anticipated as program participants for services and housing support.

- Individuals who are frequent users of State psychiatric hospitals, crisis services and jails/prisons often cycle in and out of all of these services and their homelessness creates barriers for them to take advantages of community treatments services and supports. A focus on developing supportive housing opportunities for this population is critical to changing these cycles.

Estimating the Number of Anticipated Program Participants

Using the results of the Point-in-Time Count shown in Table 4 the Task Force identified the Chronic Homeless Subpopulation as the primary emphasis group for this study. By the federal Department of Housing and Urban Development's (HUD) definition, the Chronic Homeless are those who have been homeless for one year or more, or have been homeless four or more times in the last three years.

The Task Force decided to expand that emphasis group by recognizing that some of the 1,364 individuals identified as seriously mentally ill and some of the 2,932 individuals with diagnosable substance use disorder would likely be identified as chronic homeless as their homelessness tenure extends without access to appropriate housing options.

This would likely include the 816 individuals (see page 12) discharged from the State psychiatric hospitals to homeless shelters, hotels or correctional facilities and the 286 individuals identified in the prison study (see page 18) as having prior contact with the State hospitals and/or prison.

There is a rural counterpart to the urban chronically homeless population that is not captured in the Point-In-Time Count because they do not live in shelters, but instead experience excessive instability and frequent moves in a "guest-host" relationship with family and friends. For persons with mental illness or substance abuse disorders, this lack of stability leaves them with the same vulnerability to increased access of crisis services that is seen in the traditionally urban chronically homeless population.

In conclusion, the Task Force elected to focus on about 1,700 chronic homeless individuals with mental illness, developmental disability and/or substance abuse disorders as a conservative, yet supported place to start for defining the target group needing permanent supportive housing for purposes of this study.

Chapter 3. Successful Supportive Housing Programs in North Carolina

North Carolina has experienced success in the provision of supportive housing. The Task Force recognized these successes and invited presenters from a variety of supportive housing models, both transitional housing and permanent housing.

The Task Force also heard presentations on funding streams that have successfully supported the development and financing of supportive housing models. This chapter provides a brief description of successful models used in North Carolina and common elements of successful programs. The next chapter focuses on financing and development models.

Models of Supportive Housing

Housing First – Permanent Supportive Housing for Homeless Persons

Lennox Chase, an example of Housing First that opened in 2003, is a stand alone, supportive housing complex located in Wake County for individuals with low incomes, many of whom were formerly homeless.[16] This is a successful example of the provision of long term quality of life while producing cost savings.

The development provides 36 efficiency apartments (each with a kitchen, bath, bedroom and living area) designed for single room occupancy. All residents pay rent based on the individual's income. Case management and crisis management services are provided by an on-site social worker. When needed, residents are linked with additional community supports. Lennox Chase is an example of the use of the Housing Credit and Targeting/Key Programs financing options described in the next chapter.

A cost analysis[17] indicates that overall costs have fallen from $377,142 in the two years before entry to $265,785 for 21 residents who were in the complex for two years or longer, a decline of 29.53% including the cost of the social worker. Further, the costs for inpatient substance abuse treatment for these individuals fell from $127,721 to zero after moving into Lennox Chase. Outpatient mental health services fell from $85,381 to about $4,000. Costs for incarceration fell from $3,486 to zero. The cost of medical treatment has risen from around $110,550 to $201,604 including care for two residents that suffer from chronic medical conditions (heart problems, emphysema, diabetes, asthma, high blood pressure and chronic obstructive pulmonary disorder). This is consistent with national studies that have documented that it is common for medical costs to increase for

[16] Lennox Chase was developed by Downtown Housing Improvement Corporation (DHIC) founded in 1974 to provide affordable housing services for residents of the Triangle area.
[17] Walsh, A. et al., *The Cost Effectiveness of Supportive Housing: A Service Cost Analysis of Lennox Chase Residents*, UNC-CH School of Social Work, Jordan Institute for Families, December 2007.

two to five years once homeless persons living in permanent housing, as they begin to stabilize chronic and acute conditions that were exacerbated during the individual's homeless experience.

Transitional Supportive Services Model

Bridges of Hope demonstrates a transitional supportive services model. This scattered site pilot program in the East Carolina Behavioral Health (ECBH) LME identified high utilizers of crisis services and provides wraparound support and transitional housing with 24-hour access to the on-site Help Center. The housing is a cluster of apartments integrated within a larger apartment complex, with a Help Center near by, located in a safe neighborhood with easy access to local resources (bus line, stores, pharmacy etc). A program strength is good communication between all systems – landlords, community providers, hospital, judicial and other institutions. The ultimate goal of Bridges of Hope is to give individuals the knowledge and skills they need to live independently wherever they chose. The initial design was for persons to come and stabilize and then move to homes of their choosing, though there is no program requirement for them to relocate once services are no longer needed.

The ECBH LME provided initial funding and identified 15 of the most chronic users of crisis services who had limited success in remaining free from institutions for long periods of time. These individuals had experienced on average at least:

- 10 hospitalizations within a lifetime.
- Long term hospitalization (length of one to four years).
- Multiple, back-to-back hospitalizations within the year prior to pilot.
- Incarceration often seen between hospitalizations.

Typical length of time that an individual participates in the program is one to two years, depending on individual severity and need. The time period allows for:

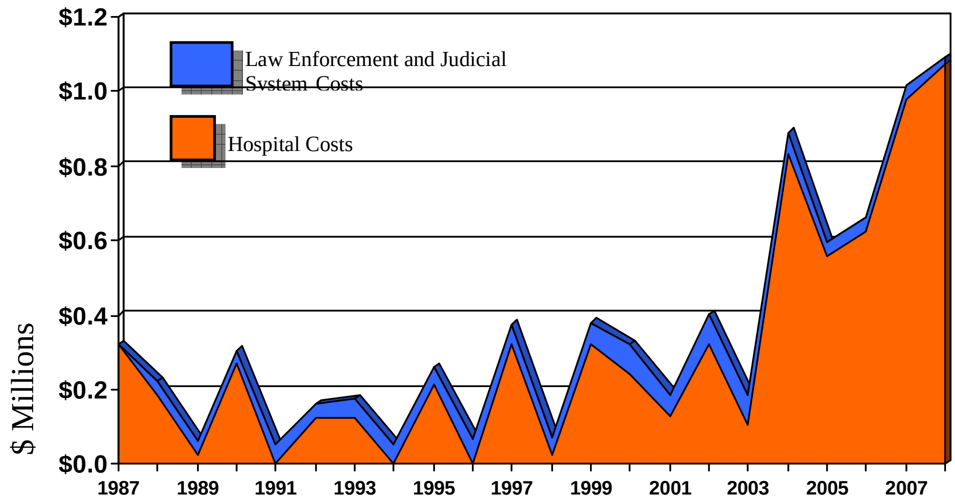
- Resolving barriers between systems that previously resulted in hospitalization and/or incarceration.
- Improvement in the individual's rental history and readiness to live independently in permanent housing.
- Introduction of the individual to services and supports in the community.
- Avoidance of hospitalization, incarceration and homelessness.

The 24/7 Help Center is an integral part of the transitional housing program, accessible to individuals at any time. The staff receives ongoing training for crisis and advance crisis interventions and mental health. A "Good Payee" system ensures landlords are paid monthly and reduces eviction due to non-payment. The rental rate is affordable with a month-to-month rental option.

As shown in chart 2, costs for the State for these 15 individuals prior to entrance into Bridges of Hope pilot exceeded $1 million total.[18]

[18] Source: Public Records/ Judicial Records; Hospital Records; Consults with law enforcement; Inter-rater reliability test. Bridges of Hope, 2010 presentation.

Chart 2. Annual costs associated with 15 participants in the Bridges of Hope pilot program prior to admission: 1987 - 2007



For a State investment of $250,000 (a quarter of what was spent in crisis care), these results were achieved:

- 100% avoided re hospitalization for periods greater than 30 days.
- 100% avoided eviction.
- 100% avoided incarceration for periods greater than 30 days.
- 100% avoided homelessness.
- 80% successfully transitioned to independent living and successfully linked with transportation, recovery classes, job skills training, budgeting assistance, and medication management.

Cost is estimated at about $250,000 for each catchment area to support about 20 individuals. These costs are for services not covered by Medicaid, including the salaries of off-duty crisis intervention team (CIT) officer to work at Help Center during crucial hours, and for mental health staff associated with a critical access behavioral health agency (CABHA) providing 24 hours coverage, training for staff, transition planning in institutions, and resources for emergency basic needs.

Peer Support Housing

North Carolina's Oxford Houses are an example of peer support housing. For individuals in recovery from substance abuse who are committed to abstinence, studies have shown that alcohol- and drug-free housing can support their sobriety following treatment. Oxford House™ is a recognized national best practice model for effectively promoting long-term abstinence by providing peer-operated recovery homes and a level of care not found in other settings.

Oxford Houses lease existing housing stock where residents collectively pay the rent and expenses. Residency is not time limited. Each group recovery home operates under a charter from Oxford House, Inc., the 501(c) (3) nonprofit umbrella organization that oversees home development and continuing operations. Oxford House staff provides 24-

hour on-call services, support services such as coordinated outreach to associated treatment providers, drug courts, 12-step groups and other community supports that the residents need.

Since 1990, the DMHDDSAS has supported the development of Oxford Houses through a revolving loan program that currently utilizes $350,000 of recurring State appropriations and federal Substance Abuse Prevention and Treatment Block Grant funds. These funds provide staff that supports the establishment of six new, self-run recovery houses throughout the State of North Carolina. As of January 1, 2011, Oxford House of North Carolina had a total of 140 Oxford Houses in 29 cities with 767 beds for men, 259 beds for women, and 17 beds for women with children. Oxford House of North Carolina also has a successful Criminal Justice Initiative for persons recovering from substance abuse who are leaving incarceration. The initial goal of this 2005 initiative was to serve 20 re-entering individuals annually, which was exceeded by 250% resulting in over 266 men and women accessing clean, safe, and affordable drug-free housing to date.

From January 2009 through December 2009, Oxford House received an average of 203 applications for residence per month but only had capacity for an average of 147 admissions per month resulting in an average unmet demand of 56 units or beds per month or 672 per year. Oxford Houses offer a cost-effective means of providing a disciplined, supportive, open-ended, alcohol- and drug-free living environment for individuals in recovery. To meet given demand, more Oxford Houses are needed throughout the State, particularly in some eastern and coastal counties not currently served. In addition, there is a need to extend services for high-risk populations, particularly women with children and persons leaving prison.

Support Services Coordination

An example of this model is the Durham LME's System of Care for Adults (ASOC) based on an organizational framework for planning and delivering effective practices, services and supports that embrace individualized, culturally competent and recovery oriented care. This is a way of doing business based on collaboration and partnership. The system is "non-categorical" focusing on a population shared across multiple community systems. The vision statement is:

> "*With our community partners Durham Adult System of Care will develop a more integrated, streamlined service delivery system based on best practices, outcomes and accountability while providing leadership for system level change and continuous quality improvement.*"

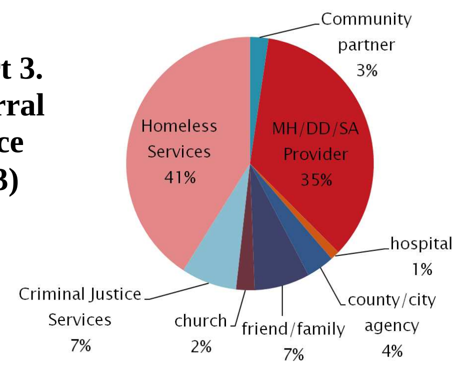
All participating organizations, departments and systems collaborate and are committed to the values and principles of system of care with focus on shared responsibility and shared actions which evolve over time. The adult system of care is driven by:

- Seamless access to services.
- Continuous quality improvement.
- Outcome based measurements and the incorporation of research.
- Knowledge.
- Treatment promoting a recovery oriented community for all citizens.

At the macro level, system improvements include homeless services, criminal justice services and crisis services. At the micro level, change has occurred through Care Review with a focus on individuals who are homeless or at-risk of homelessness with complex needs and are high users of public services. Care Review is a multi-disciplinary, collaborative process between professionals, the individual and members of their support team to increase access to needed services and supports. Care Review is based on self determination and recovery to improve quality of life.

Beginning with six available slots each month, and now offering 18 slots each month (not including emergencies/special initiatives), the ASOC hosted over 115 Care Reviews the first year and established a priority population of people who were homeless/at-risk of homelessness and high users of public services. Individuals are referred to the program from a variety of sources.

Chart 3. Referral Source (n=83)



Through community planning meetings and seven Care Review Teams[19], over 41 people participate from 24 different community agencies and churches. The goals of Care Review are:

- Improve timely access to needed services and supports.
- Improve retention in services and supports.
- Provide an opportunity for comprehensive and holistic planning that eliminates system barriers.
- Gain a better systemic understanding of what worked and why as well as what didn't work and why.

Each Care Review Team creates an individualized plan for people who are homeless or at risk of homelessness that addresses unmet needs, incorporates strengths and interests, and specifies action steps to achieve individual goals in the life domains such as safety,

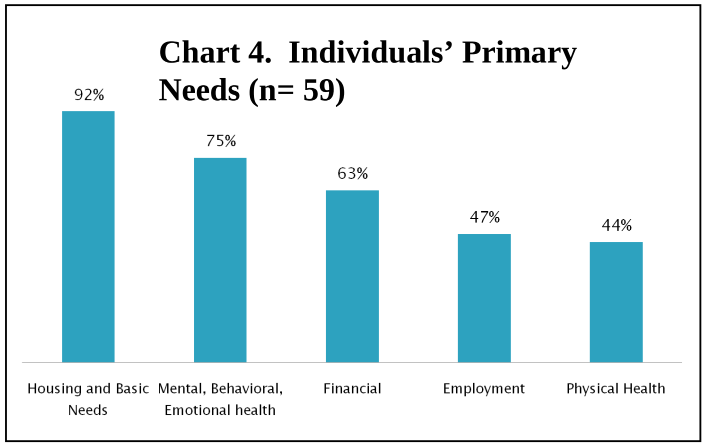
[19] The seven Care Review Teams include two core teams, a criminal justice team, a homeless shelter team, a transition age team, a Hispanic team, and a "Top 50"team.

housing and basic needs, education, employment, financial, citizenship, physical health, mental and behavioral health.

Action Plans are created during Care Review through a process based on self-determination. The plans are composed of goals that an individual sets for himself/herself and are carried out by many members of the Care Review Team and individuals' support team. The Action Plans are the foundation of the follow-up at one, three, six and nine months.

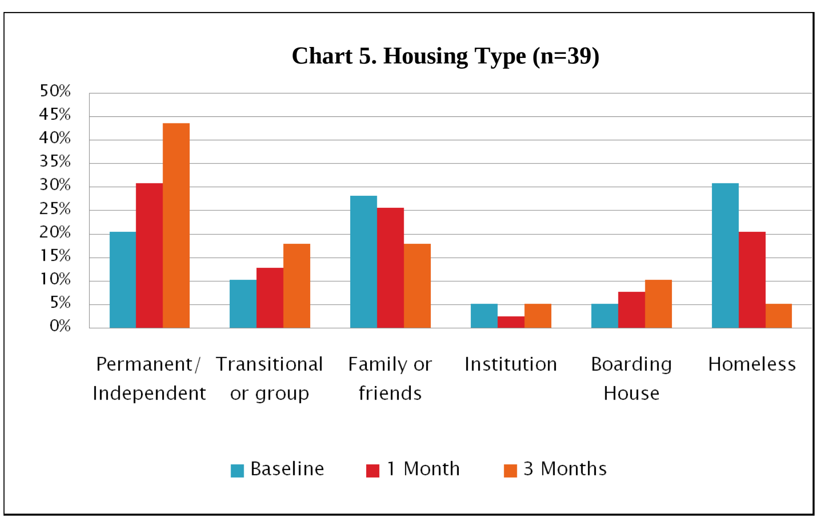
Individuals served:

- 92% of individuals identify stable housing as a primary need
- 37% are considered homeless
- 47% do not have health benefits
- 60% have no income
- 71% have current or previous involvement with the criminal justice system
- 39% have an identified mental health or substance abuse need but are not connected to services



Successes of the Durham Adult System of Care:

- 100% of homeless individuals coming through Care Review were housed within three months and have remained successfully housed.
- Emphasis on natural supports.
- People are accessing mental health and substance abuse services in a timely manner.
- Diverting more people from the State hospital.
- Reducing the likelihood of re-arrest for people with criminal histories.
- The whole community takes ownership of Care Review.



Permanent Supportive Housing and Property Management

Community Alternative for Supportive Abodes, Inc., better known as CASA, was created by Wake Area Mental Health Program in 1992 to develop, manage, and own rental properties in Wake, Durham, and Orange County. CASA is a nonprofit real estate developer and property management agency, specializing in the housing needs of low income citizens, including individuals with disabilities. Their mission is:

To create affordable housing and opportunities for successful living.

CASA owns 253 units in 69 properties including both supportive housing for individuals of low wealth who live with a disability and mixed income housing for individuals earning less than the area median income (AMI), typically 40% to 60% of AMI. In Wake County, this means individuals earning $16,151 to $32,280. Supportive housing units include individuals with disabilities, histories of homelessness, and mental illness. Mixed income housing units include individuals employed in the workforce as teachers, EMTs, firefighters, and service industry workers.

CASA business model is based on purchase, rehabilitation, and construction funding obtained through HUD, NCHFA, county, city, and/or town funds. It is necessary that a portion of funding come from up front grants to minimize mortgage related development costs. Funding for supportive services comes from local governments as well as Medicaid. Income from the properties supports CASA operating expenses. CASA's operating expenses include some support services, which include a half time psychiatrist and other professionals. CASA properties are compliant with the Americans with Disabilities Act (ADA) and use green energy building materials.

Supportive housing tenants are referred from service providers who continue to provide support to the tenant. CASA accepts rental subsidies when available and works with service providers and tenants to keep residents housed and often successfully house households who have been rejected from other landlords. CASA residents must comply with a standard lease and receive assistance on employment and basic skill building.

Based on a survey of participants that indicated they wanted to work, CASA received funds to train persons to provide landscaping services. Five to 10 are hired by Community Property Alternatives, is a in-house landscaping business that employs CASA tenants with disabilities in part-time work to serve CASA properties and as well as outside contracts.

Housing Search

To reduce the need to develop new units it is important to access all units available to the anticipated program participants. NCHousingSearch is a statewide, bi-lingual housing search tool that tracks available affordable housing units. The site is free to landlords and consumers. Landlords list available properties and can list detailed information about each available unit. Consumers are able to go online, or call an 800-bi-lingual call center, to seek information about affordable units that are immediately available for lease. The site is capable of listing all types of housing units, including licensed facilities and unlicensed supportive housing units. Furthermore, a password protected portal can allow case workers to access specific information, not available the general public, about units that are available to households with special needs. A staff position at the State level would be needed to coordinate case worker access to the protected portal.

SSI/SSDI Outreach, Access and Recovery (SOAR)

The Social Security Administration identifies that only 15% of all homeless people who apply for disability benefits are approved at their first request. Furthermore, homeless persons with mental illness or substance abuse disorders have a smaller rate of approval.

SOAR, is a specific strategy used to assist first time applicants in the process of obtaining disability income. In North Carolina, there are 11.5 full time equivalent staff who work exclusively with SOAR. In addition, some communities have non-dedicated staff that occasionally assist applicants using the SOAR methodology. Most SOAR staff are hired by nonprofits. Since tracking of SOAR outcomes began, SOAR workers have a 77% success rate for 244 first-time homeless disability applicants. Each person approved for SSI is automatically eligible for Medicaid. In addition, since June 2, 2010, these successful applicants have brought $1,141,813 in cash benefits into the State. These cash benefits can be used, in part, to pay housing costs, reducing the monthly rental assistance required to assist those households.

Common Elements of Successful NC Housing Models

The five housing models and two programs for improved access to housing described in this chapter have all been successfully demonstrated in North Carolina. The success of each of these programs is based on some common elements.

- ✓ LMEs can identify high cost / high risk individuals served in the MH/DD/SA services system.
- ✓ Tenants have all the rights and responsibilities of a lease.
- ✓ Medicaid is utilized for enhanced community services, including community support team (CST), assertive community treatment team (ACTT), and targeted case management (TCM-MH/SA) as preventative measures.
- ✓ Work creates a meaningful day, enhances self-worth and contributes to financial independence.

- ✓ When individuals in transitional housing settings receive support to choose to remain in the transitional housing until ready to move to permanent housing setting, they experience less disruption and loss of gains made in stabilization and recovery.
- ✓ Each program allows the individual to return to the program if hospitalized.
- ✓ Each program has built successful relationships with landlords in the community and staff acts as a liaison between a tenant and the landlord when necessary.
- ✓ Staff helps to significantly reduce crisis situations from escalating to the point of hospitalization, arrest and/or eviction. Best practice says the quality and easy availability of services is a key in stability.
- ✓ Training is offered to providers on developing a permanent housing plan, access housing, and relating to landlords and supportive services.
- ✓ When an individual is discharged from an institution, multiple county agencies are involved to increase success of the transition to the community. A System of Care approach that fosters community collaboration is essential in these programs and recognizing groups that are already in operation.
- ✓ Support is critical in "bridging" the transition of an individual from an institution to the community. A relationship with treating professionals and/or peer support prior to discharge that follows to the community creates success.
- ✓ Housing immediately after discharge from an institution may be transitional or permanent, and intensive wraparound services must be comprehensive and ongoing.
- ✓ Individuals from prison have particular barriers to overcome with landlords and to support independence after experiencing 24/7 care in prison.
- ✓ When access to existing units is readily available, the need for development of new housing and services is reduced.

Summary

Given North Carolina's success in the establishment of supportive housing over the last 18 years, the Task Force recognized the importance of building on the models that have worked to provide long term quality of life and cost savings over time. The Task Force found the following components to be essential.

- **An individualized transition plan is designed based on the needs of the individual, including utilization of resources in the community to support transfer to permanent housing.** The transition plan also includes what works to keep the individual out of the hospital or jail and therefore in continued housing as well as what has not worked in the past that resulted in eviction (often due to hospitalization, arrest and jail). This population may experience greater medical treatment and increased costs for medical care.

- **The connection to community services must begin prior to discharge from psychiatric hospitalization or jail/prison.** Service providers, including peer support specialists, should engage these individuals, develop relationships, and assist with detailed transition planning, including housing options and the initiation of SSI application if needed. The establishment of these relationships and the thoroughness of planning will help bridge the individual into the community.

- **Upon discharge from psychiatric hospitalization or from jail/prison a transition period of 3-6 months is necessary where intensive wraparound services must be provided.** Housing may be transitional or permanent but during this transition time having staff on site and available 24/7 is critical. The focus is on securing financial supports such as SSI, and other entitlements, ensuring availability of medications, addressing medical needs, securing needed articles for a home, and assisting individuals to learn tenancy expectations and to support in working through various transition issues.

- **A System of Care approach for this target population is most effective in assuring care coordination across multiple agencies.** The LME Care Coordination function could serve as leaders in convening System of Care efforts within their catchment areas.

- **Funding streams must be flexible to accommodate the development of the variety of housing models required to accommodate the various needs of the emphasized population.** These are discussed in Chapter 4.

Chapter 4. Funding for Supportive Housing

Funding supportive housing requires coordination of a complex group of systems and funding sources and partnering with multiple federal and State agencies with various laws, rules, and regulations. Further, coordination of the capital for development, operating subsidies, and needed services and supports is challenging, especially since services and supports are largely disability specific and Fair Housing laws require housing, in most cases, to be disability neutral. Described below are the major supportive housing funding programs.

NC Housing Finance Agency Administered Housing Programs

Capital Programs

- Housing Credit (LIHTC) encourages the production of rental housing for low-income households by allowing a 10-year federal tax credit. All properties serve households below 60% of area median income and since 2004 require 10% of all units must target to persons with disabilities at 30% of area median income (AMI) or below.

- Rental Production Program (RPP) provides loans of up to $1 million per development for the construction of rental housing for households below 50% of area median. This program is used in conjunction with some of the Housing Credit Projects, furthering efforts to reduce mortgages needed to cover development costs and in turn, reducing rent amounts needed for operation.

- Supportive Housing Development Program (SHDP) provides interest-free loans of up to $600,000 per development for the production of emergency, transitional and permanent housing for homeless families and individuals, and persons with special housing needs. This program serves households below 50% of area median income, and gives priority to households below 30% of area median income

Operating Subsidy Programs

- Targeting Program is a requirement of the Housing Credit Program that 10% of units must be ‘targeted’ to persons with disabilities at 30% of AMI or lower. The affordability mechanism, which covers the difference between tenant rent and actual unit operating expenses, is determined by the development team and can range from Project Based Rental Assistance, Tenant Based Rental Assistance, rent skewing, local programs, Key, etc.

- The Key Program provides operating assistance for persons with disabilities, making the rents affordable to individuals on SSI incomes. This program is funded in partnership with the North Carolina Department of Health and Human Services and is available to existing affordable housing developments that are participating in NCHFA programs such as the Supportive Housing Development Program and the Housing Credit Program.

Note: In July 2006, the NC General Assembly created the 400 Initiative by appropriating capital funds to NCHFA through the Housing Trust Fund and operating subsidy funds to DHHS to create 400 units of supportive housing. These funds were used through the programs described above and three other programs – PLP 400, SHDP 400, and Key Reachback.

PLP 400 was a variation of the Preservation Loan Program that provided capital funds for older properties for modest rehabilitation. To receive PLP 400 funding owners had to agree to create a minimum of five Targeted Units with a maximum of 20 percent of units creating access to Key operating assistance.

SHDP 400 was a variation on SHDP. This version provided interest free construction lending, permanent financing up to 100 percent of the development costs or $1,200,000, which ever was less, and paired it with operating assistance for up to 100% of the units.

Key Reachback made Key available to existing NCHFA properties that could opt into the Targeting Program and thereby access Key operating assistance up to 20 percent of the units.

The General Assembly continued Capital funding for two additional years and as of December 31, 2010, the 400 Initiative has successfully funded over 1,396 units, in over 192 properties, in 133 cities, in 71 counties of North Carolina in conjunction with the ongoing efforts of the programs listed above.

Programs administered by the NCHFA are funded by both federal and State funding streams. The main federal funding is Low Income Housing Tax Credits and HOME funds. The main State funding is NC Housing Trust Fund. Many funding streams and NCHFA programs emphasize matching funds either from the State or from localities. For example, the federal HOME funding requires a 25% match, thus for every million of HOME funds must be matched at the State level by $250,000.

Section 8 Housing Voucher Program

There are 131 public housing authorities (PHAs) in North Carolina, including 75 PHAs that administer a total of 56,184 Housing Choice Vouchers (Section 8).

The 75 PHAs that administer Housing Choice Vouchers have mandatory as well as discretionary policies that determine how the Voucher program actually works. Mandatory policies are the same across all PHAs and include basic eligibility, rent calculations, program participation requirements, and federal fair housing laws and policies. Discretionary policies include granting certain applicants preference on waiting lists. PHAs are permitted – but not required – to adopt preferences that favor people with disabilities, including a preference for people receiving SSI. PHAs must have these preferences approved by HUD through the submission of their PHA Plan.

While PHA Vouchers are primarily designed as tenant-based assistance to enable Voucher households to chose where they want to live, PHAs are permitted to use up to 20 percent of their Voucher funding as project-based assistance. Under this model, the Voucher is actually pledged to a property, and households are referred to that property from the PHA waiting list.

From time to time over the past ten years, Congress has appropriated special disability vouchers that can only be used by people with disabilities. In North Carolina, 27 PHAs received a total of 2,095 disability vouchers through several different voucher programs. The tables below provide specifics on where and when these vouchers were received.

Table 5. Section 8 Mainstream Housing Opportunities for Persons with Disabilities (Section 811-funded vouchers with five-year renewable Annual Contribution Contracts)

Housing Agency	Vouchers	Year Awarded
Eastern Carolina Human Service Agency	75	2001
Housing Authority of Greensboro	50	1997

Table 6. Section 8 Vouchers for People with Disabilities
(Vouchers with one-year renewable Annual Contributions Contracts)

Housing Agency	Vouchers	Year Awarded
Carteret (Coastal) Community Action	50	1998
Franklin Vance Warren Opportunity Inc.	150	1998
Housing Authority of Asheville	75	2000
Housing Authority of Charlotte	275	1999
Housing Authority of Durham	200	2001
Housing Authority of Greensboro	400	1997, 2000, 2001, 2002
Housing Authority of High Point	50	1997
Housing Authority of Lexington	50	2000
Housing Authority of Wake County	100	1998
Housing Authority of Winston-Salem	451	1997, 1998, 1999, 2001, 2002
Northwestern Regional Housing Authority	64	1998
Town of East Spencer Housing Authority	50	1998
Troy Housing Authority	25	2001
Western Carolina Community Action	30	1998

In HUD's federal FY 2008 budget, Congress appropriated $30 million in new funding to support the creation of up to 4,000 new vouchers that are exclusively set-aside for people with disabilities. These vouchers are being made available to PHAs through two Notices of Funding Availability published in late November 2008. These new funds from

Congress re-institute a federal policy that existed from 1997-2002, when Congress provided over 60,000 new vouchers targeted exclusively to non-elderly people with disabilities.

Despite these new Housing Voucher investments, the standard Section 8 program is severely underfunded. Most North Carolina administrators have closed waiting lists since households on current lists are commonly expected to use all available vouchers for the next two to five years.

Shelter Plus Care

The purpose of HUD's Shelter Plus Care (S+C) Program is to provide rental assistance in connection with supportive services.[20] The Program provides a variety of permanent housing choices, accompanied by a range of supportive services funded through other sources. S+C assists hard to serve homeless individuals with disabilities and their families. These individuals primarily include those with serious mental illness, chronic problems with alcohol and/or drugs, and HIV/AIDS or related diseases.

Eligible States, local governments units or public housing agencies can apply for any of four components:

- Tenant based rental assistance, the most common form of S+C, can be requested on behalf of participants who choose their own housing units; arrangements made to deliver supportive services.
- Single room occupancy component requiring moderate rehabilitation for single-room occupancy dwellings; rental assistance is provided for a period of 10 years; owners are compensated through rental assistance payments, some rehabilitation costs and costs of maintaining the property; initial rehabilitation costs must come from other sources.
- Sponsor-based rental assistance available through a private nonprofit organization or community mental health agency established for that purpose; may request a five year grant for housing units owned or leased by the sponsor.
- Project-based rental assistance through a subcontract with a building owner; may request grant funds to provide rental assistance for five years for ready-to-rent units or 10 years for units that need rehabilitation.

Grants under S+C are awarded through a national competition held annually as published in the Federal Register and applications are submitted through one of North Carolina's 13 Homeless Continuum of Care Systems.

In 2006, DHHS began facilitating a Balance of State Continuum of Care (BoS) that involved linking over 80 rural counties into one regional Continuum and providing

[20] For additional information see: www.hudhre.info/index.cfm?do=viewShelterPlusCare

extensive technical assistance and application assistance. Prior to the creation of the BoS, most of the other 12 continua were primarily using S+C funds to renew existing S+C programs, rather than to create new PSH housing opportunities. With the creation of the BoS Continuum many rural communities have been able to supplement their permanent housing resources, mostly through the Shelter Plus Care program. The ability of all the Continua to create new permanent housing projects is dependent on the federal allocation of funds to the HUD funded programs. To date more than 1000 units of Shelter Plus Care have been funded in North Carolina.

Money follows the Person

North Carolina's Money Follows the Person (MFP) demonstration project, administered by DHHS, is used to help qualified individuals move from qualified inpatient facilities to homes of their own (qualified residences in the community). The federal Centers for Medicare and Medicaid Services (CMS) awarded MFP funding to North Carolina in 2007 to support the transition of individuals to their own homes and to change systems through increased home and community based services, elimination of barriers, continued provision of services and quality improvement.[21]

A qualified individual is someone who currently resides and has resided for at least three months in an inpatient facility (nursing facility, developmental center, ICF/MR, hospital); receives Medicaid benefits for inpatient services furnished by the inpatient facility; and continues to require the level of care provided by the inpatient facility. Qualified facilities include nursing facilities, State operated Developmental Centers, Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), and acute care facilities.

Qualified residential destinations in the community include:

- A home owned or leased by the individual or the individual's family member.
- An apartment with an individual lease, with lockable access and egress, and that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.
- A residence in a community-based setting in which no more than four unrelated individuals reside.

Summary

The Task Force found the following as requirements for funding of supportive housing programs.

- Supportive Housing must have capital, operating assistance, and access to services to be successful.

[21] MFP activities are funded by federal dollars that have been allocated through the Deficit Reduction Act and through the Patient Protection and Affordable care Act (PPACA) and are managed by CMS.

- Funding streams for each of these comes from multiple individual sources and some from bundled sources.
- Funding streams are received from multiple federal and State agencies.
- Coordinating the different funding sources and the development of supportive housing is complex.
- Leveraging federal dollars is critical to obtain maximum funding available and reducing the State's share of responsibility.
- Receiving funding from multiple sources is often necessary for any one project.
- Flexible funding to provide supports and services that are not "billable" is very important to allow for training, tenancy supports, and other coordinating actions.
- Supportive services are almost always disability specific and housing development and operating assistance is almost always disability neutral.
- Section 8 waiting lists are long, most are closed, and many do not have a preference for disabilities. Because of the complexity of funding, securing technical assistance to create sound funding and development options is critical.

Conclusions

Consistent and level funding for the NC Housing Trust Fund is critical to provide the most flexible financing for affordable supportive housing across North Carolina. It leverages federal affordable housing funding streams and provides opportunities in communities that would otherwise go unmet.

Consistent appropriations of DHHS Operating Subsidy must be made available to fill the gap between what an individual at 30% of AMI or SSI income can afford to pay for housing and what is needed to properly maintain the housing. The use of this in the Key Program makes supportive housing available while SOAR activities take place and while waiting for Section 8 to become available ("bridging the gap between when federal source become available and when housing is needed). This in turn brings in additional federal dollars allowing release of those state dollars to help the next person. The appropriation must include administrative costs to cover the operation and oversight of the program and consider that with each new unit the amount of recurring appropriations grows.

The Housing and Homeless Office within the Department of Health and Human Services is vital and necessary to coordinate housing efforts across DHHS and to provide one point of contact for NCHFA and other housing developers. This allows one office to coordinate all the disability specific needs with disability neutral housing providers, complying with the Fair Housing Act and the Olmstead decision. Additionally, this office promotes best practice policy across housing referrals systems, housing development, and housing assistance.

Continue and increase funding for the NC Interagency Council for Coordinating Homeless Programs (NC ICCHP). This will continue the Balance of the State

Continuum of State application and allow for the population of emphasis identified in this report to remain a top priority.

Securing technical assistance to create sound funding and development options is critical due to the complexity of funding streams and housing development. Additionally, the ICCHP and the Housing Coordination and Policy Council should share each other's knowledge to allow further understanding of supportive housing initiatives across the State.

Chapter 5. What Have Previous Studies Found?

The Task Force reviewed studies done in North Carolina and elsewhere that focused on providing effective housing and supportive service models for individuals with mental illness and/or addiction who also were homeless and most likely to frequent State psychiatric hospitals, jails/prisons, and crisis services.

Studies from Across the Nation and Canada

Nationwide Studies

In 2004, Lewin Group compiled another illustration of supportive housing being cost-effective.[22] The chart in table 7 shows the costs per day of serving individuals in supportive housing that would otherwise be homeless compared to more restrictive and potentially more expensive settings in nine cities across the country.

Table 7. Cost of Serving Homeless Individuals in Nine Cities (2004)

City	Supportive Housing	Jail	Prison	Shelter	MH Hospital	Hospital
Atlanta	$32.88	$53.07	$47.49	$11	$335	$1,637
Boston	$33.45	$91.78	$117.08	$40.28	$541	$1,770
Chicago	$20.55	$60	$61.99	$22	$437	$1,201
Columbus	$30.48	$70.00	$59.34	$25.48	$451	$1,590
Los Angeles	$30.10	$63.69	$84.74	$37.50	$607	$1,474
New York	$41.85	$164.57	$74	$54.42	$467	$1,185
Phoenix	$20.54	$45.84	$86.60	$22.46	$280	$1,671
San Francisco	$42.10	$94	$84.74	$27.54	$1,278	$2,031
Seattle	$26	$87.67	$95.51	$17	$555	$2,184

According to a study by the Lewin Group, nationally respected health economists, supportive housing is a better use of public funds than the alternative settings in which people with mental illness are often served. Even when the costs are comparable, that is, in shelters, the greater potential for stability and community inclusion offered by supportive housing make it the better investment for states and communities to make for these vulnerable residents.

[22] Lewin Group, Supportive Housing for People with Mental Illness: Regaining a Life in the Community, September 25, 2007. Retrieved from http://www.dhmh.maryland.gov/mt/pdfs/Reference%20-%20Transformation%20-%20Supportive%20Housing.pdf

One HUD study[23] of homeless persons with mental illness who move into permanent housing finds that those persons with comparatively more contact with community based services prior to entry into housing as well as during their stay in housing are more likely to remain stably housed than those persons who were experiencing inpatient admission and had used emergency services during their stay in permanent housing. The study also notes that it is important for programs to be sensitive to the placement of supportive housing. "Careful consideration should be made as to the location of permanent housing and should avoid placing permanent housing residents in neighborhoods with high crime rates and drug activities that inadvertently increase the risk of relapse for residents."

Another HUD study[24] found that participants in Housing First programs are likely to have increased income by the end of the first year of residency. In addition, the level of substance abuse severity decreased with fewer resident using substances or being impaired by substance use.

A report by Oakley and Dennis[25] reviewed 10 studies of the National Institute of Mental Health and additional studies of the National Institute on Alcohol Abuse and Alcoholism, finding that treatment outcomes improved if housing, sustenance and security needs were addressed first. Stable housing becomes a critical therapeutic intervention.

New York City

In the landmark 2002 study by Culhane, Metraux and Hadley[26] conducted in New York City that tracked homeless people with mental illnesses for two years before and after being housed in supportive housing showed marked reductions in their length of hospitalization, shelter and prison stays. This represented about $16,282 annual reduction in cost per person versus the pre-housed cost of $40,451 per person.

Other findings of this study include:

- "Reductions in services may nearly cover the costs of supportive housing intervention in the aggregate…., it remains a major public policy challenge to

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[23] "Predicting Staying In or Leaving Permanent Supportive Housing That Serves Homeless People with Serious Mental Illness", U.S. Department of Housing and Urban Development, Office of Policy Development and Research, March 2006.

[24] "The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness", U.S. Department of Housing and Urban Development, Office of Policy Development and Research, July 2007.

[25] "Responding to the Needs of Homeless People with Alcohol, Drug and/or Mental Disorders", by Deirdre Oakley and Deborah Dennis, in Homelessness in America, ed. Jim Baumohl, for the National Coalition for the Homeless, Oryx Press, 1996.

[26] Dennis P. Culhane, Stlephen Metraux and Trevor Hadley, *Supportive Housing for People with Mental Illness: Regaining a Life in the Community*, September 25, 2007. The Webcast was funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services through a contract to JBS International, Inc., and was developed in collaboration with the National Association of State Mental Health Program. Retrieved from http://www.dhmh.maryland.gov/mt/pdfs/Reference%20-%20Transformation%20-%20Supportive%20Housing.pdf

shift funds from one set of purposes (health, jails, prisons) to another (housing or housing support services).

- "Placing homeless persons with severe mental illness into subsidized permanent housing with social service support …provides a more humane alternative to living on the streets and in shelters, and providers report retention rates in such housing to be upwards of 70 percent in the first year after placement.
- Permanent supportive housing resulted in a 60% reduction of state hospital use.

Pathways Housing First of New York

SAMHSA's National Registry of Evidenced-based Programs and Practices (NREBPP) lists Pathways" Housing First Program as an evidenced-based program. Housing First, a program developed by Pathways to Housing, Inc., is designed to end homelessness and support recovery for individuals who are homeless and have severe psychiatric disabilities and co-occurring substance use disorders. Begun in New York, the model has been replicated in Washington, D.C. and Philadelphia as well as many other U.S. cities and other countries.

Pathways' Housing First model is based on the belief that housing is a basic right and on a theoretical foundation that emphasizes consumer choice, psychiatric rehabilitation, and harm reduction. The program addresses homeless individuals' needs from a consumer perspective, encouraging them to define their own needs and goals, and provides immediate housing (in the form of apartments located in scattered sites) without any prerequisites for psychiatric treatment or sobriety. Treatment and support services are provided through an Assertive Community Treatment (ACT) team and may include psychiatric and substance use treatment, supported employment, illness management, and recovery.

The results of this program demonstrates greater stability in housing, increased perceived consumer choice in housing and services, and lower costs of housing and services. Pathway's program costs run about $21,000 annually per person.

The Pathways model, has also documented one of the highest permanent housing retention rates among all studies of housing for homeless persons with mental illness. Pathways has a five year retention rate of 88%, compared to other programs with documented five year rates of closer to 55%.[27]

Oregon

In July 2004, Oregon Office of Mental Health and Addiction Services created a Community Mental Health Housing Fund out of the revenues from the sale of Dammasch

[27] Dennis P. Culhand, Stephen Metraux, and Trevor Hadley, *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, University of Pennsylvania, Housing Policy Debate, volume 13, issue 1; Fannie Mae Foundation 2002.

State Hospital to increase their housing stock for persons with mental illness.[28] In 2006, Portland conducted a study of 35 chronically homeless individuals with disabilities, and found that prior to entering their Community Engagement Program; they utilized over $42,000 per person annually in emergency and hospitalization, but had a noticeable reduction in cost to $17,199 representing an annual savings of $15,006 per person.[29]

New York State[30]

The affordable housing and community development issues and needs raised by participants varied by region. However, several common themes emerged. Twelve themes germane to the issues and needs of affordable housing and community development were expressed, including quality affordable rental units, aged housing stock and "not-in-my-backyard" (NIMBY) opposition. In addition, several themes common in both rural and urban areas were identified. Listed below is a summary of the key statewide issues and needs related to the topics that were raised by the focus group meeting participants.

- **Quality Affordable Rental Units**: There is a need for rehabilitation and modernization funds for the existing rental housing stock. There is also a need for affordable/workforce housing education and outreach and zoning reform to encourage the development of additional affordable rental housing units.
- **Aged Housing Stock**: There is a need for rehabilitation and modernization funds for aged housing stock which has been subject to significant disinvestment.
- **Preservation and Rehabilitation of Units**: There is a need for additional funding for repairs or upgrades to modernize and preserve owner occupied and rental housing.
- **NIMBY Opposition**: There is a need to educate local officials, planning and school boards and community members about the benefits of affordable housing developments in order to mitigate NIMBY opposition.
- **Housing for Very Low- Income Households**: There is a need for safe, decent and affordable housing and living wage jobs for residents earning 30 percent or less of area median income (AMI).
- **Affordable Homeownership**: There is a need for first- time homebuyer programs, living wage jobs that can support homeownership and "next generation" housing for young adults.
- **Other Housing Costs**: There is a need for increased funding for the Weatherization Assistance Program and a utility cost assistance program which would assist homeowners and renters with housing-related costs.

[28] OMHAS Mental Health Housing Initiatives: Notes on Housing and Homelessness among People with Mental Illness, DHS Office of Mental Health and Addiction Services, December 2003. Retrieved from: http://www.oregon.gov/DHS/mentalhealth/publications/housing-omhasstaffmtg011304.pdf?ga=t

[29] Estimated Cost Savings Following Enrollment in the Community Engagement Program: Findings from A Pilot Study of Homeless Dually Diagnosed Adults, May 2006. Thomas L. Moore, PhD. Retrieved from http://www.shnny.org/documents/CEPCOST-BENEFITlinktoCEP_000.pdf

[30] New York State Statewide Affordable Housing Needs Study, Division of Housing and Community Renewal, May 2009.

- **Foreclosure**: There is a need for increased funding for foreclosure prevention services including pre- and post- purchase counseling, as well as emergency funds for those in the throes of foreclosure.
- **Senior Housing**: Funding is needed to create rental housing for seniors, along with supportive services, sited close to support systems and public transportation. To meet the needs of senior homeowners, additional funding for home repairs and accessibility modifications is needed.
- **Homelessness**: There is a need for emergency shelters, particularly in rural communities, as well as additional funding for existing emergency shelters.
- **Supportive Service Delivery**: There is a need for timely and effective partnerships between those who develop affordable housing and those who provide social services to individuals and families living in affordable housing developments.
- **Use of New York Main Street Program**: There is a need to adjust the Program's match requirement to attract increased participation from local businesses.

Canada

In 1991, a significant study in this area was published by McCarthy & Nelson[31] finding that after five months in a supported housing program, persons with disabilities exhibited personal empowerment as well as enhanced functioning, along with experiencing a reduction in hospitalization. In addition to promoting greater choice, self-sufficiency and community integration, research has demonstrated positive impacts in terms of cost-effectiveness and improvement in quality of life, housing stability and health and behavioral outcomes for people with mental illnesses, developmental disabilities and substance use disorders.

Studies and Findings in North Carolina

Final Plan for Efficient and Effective Use of State Resources in the Financing and Development of Independent and Supportive-living Apartments for Persons with Disabilities (A joint study by the Department of Health and Human Services (DHHS) and the North Carolina Housing Finance Agency (NCHFA) for the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, March 1, 2009.)

This report concluded:

[31] The study by McCarthy & Nelson, originally reported in the Canadian Journal of Community Mental Health, is noted as one of the best social housing evaluations studies combining multiple methods. It is referenced in many reports including the U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary, Chapter 4. Other Services and Supports*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Retrieved from: http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec6.html

> "Permanent supportive housing is the recognized best practice in meeting the housing needs of the majority of persons with disabilities. Research into housing programs for persons whose sole disability is substance abuse indicate housing models other than permanent supportive housing can be effective in supporting the recovery process.
>
> "There are three critical components to developing affordable permanent supportive housing: **Capital –** a source of funding either to purchase or build housing; **Operating Subsidy –** a mechanism to ensure the rent is affordable to extremely low-income tenants; and **Access to Services and Supports –** availability and coordination of the services and supports that persons with disabilities may need to be successful in the community.
>
> "NCHFA and DHHS believe that making independent community housing affordable to persons with disabilities is a good investment. Meeting the housing needs for persons with disabilities will require a range of strategies. Consistent annual funding will sustain the momentum built by the Housing 400 Initiative and allow development and service partners to confidently plan future supportive housing. These recommendations are important steps and build on successful models already used in North Carolina."[32]

NCHFA and DHHS made the following recommendations to continue successfully supporting North Carolinians with disabilities.

1. Continue DHHS-NCHFA Partnership in the Housing Credit and Key Programs.

2. Create a Tenant Based Rental Assistance Program.

3. Continue Smaller-Scale Supportive Housing Developments.

4. Expand North Carolina's Oxford House Partnership Pilot Program to Reduce State Psychiatric Hospital Use and to Increase Local Services for Persons with Mental Illness.

Uniform System for Beds or Bed Days Purchased: With Local Funds, From Existing State Appropriations, Under the Hospital Utilization Pilot, and From Funds Appropriated Session Law 2008-107, Section 10.15(k), April 1, 2009[33]

The North Carolina General Assembly provided funding for a demonstration project involving four LMEs to reduce their State hospital bed day utilization by holding LMEs financially and clinically responsible for the cost of that use and by providing additional resources to build community capacity. The implementation of House Bill 1473, Section 10.49 (s1-s5), Session Law 2007-323 resulted in the following changes and service delivery improvements:

[32] Quoted from the Executive Summary: (pp. 3-4)
[33] See: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm#legreports

- Each of the four LMEs showed decreases in bed day utilization, a total of 17,518 bed days or $2,940,626 in net savings. [34]
- Overall reduction in State psychiatric hospital admissions was 1,176 fewer from the start of the project on January 1, 2008. Total consumers served via new programs and usage of on-site hospital liaisons equals 4,396 through November 1, 2008.
- Readmissions within 30 days of discharge decreased (Jan. 1, 2008 – Oct. 31, 2008) by 35 percent when compared to the previous year.

During this project LMEs used a variety of programs locally, such as additional transitional housing for consumers discharged from State hospitals who otherwise would have gone to homeless shelters, a six bed residential substance abuse service for women with children, a hospital step-down unit, peer support staff, crisis respite for children and adolescents, geriatric crisis services, dual diagnosis treatment, additional staffing for crisis services, and services to transition consumers discharged from the State hospitals immediately upon discharge.

Welcome Home! Housing for North Carolinians with Disabilities Prepared by the Task Force on Housing of the North Carolina Commission for MH/DD/SAS, May 11, 2004

This report recognized many situations in which changing the system could be accomplished without massive cost or effort. Such recommendations include, but are not limited to, the following:

1. Greater incentives should be made available to attract and hold private providers who seek or can help to provide housing for people with disabilities. Such incentives should include tax credits, waivers, special assistance options and public support.

2. Greater efforts should be made to remove barriers at the community level that prevent development of housing alternatives for people with disabilities. Such barriers are often found in zoning laws, land use plans, housing codes and many others. These barriers are often the unintended result of actions taken locally to address other issues.

3. Barriers to employment for people with disabilities based on inadequate housing arrangements need closer examination.

4. North Carolina should support the creation of State-funded specialty housing and support services for people with severe disabilities and intense needs. The program should allow for maximum flexibility based on local needs and should restrict housing size to no more than three people with disabilities.

[34] This equates to a net savings of $2,940,626 (this figure was obtained by multiplying the established bed day rate which is $548 per day times the projected bed day reduction of 17,518 and subtracting the funds that were allocated to the pilot LMEs ($6,659,238) leaving a net of $2,940,626. This is the 2009 established bed day rate.

5. Mechanisms should be developed to utilize the HCBS waiver [CAP/DD] to support individuals in DDA group homes as well as the utilization of the North Carolina Special Assistance program for individuals with disabilities living in other than licensed residential settings.

6. North Carolina should create a State-funded operating subsidy program, tied to existing housing production activities that would increase the supply of housing that is affordable for extremely low income persons with disabilities. This proposed new subsidy program would bridge the current gap between tenant income and the cost of operating housing units by helping to underwrite the operating costs of housing for low income persons with disabilities. [Note: This is the Key program currently administered by the NCHFA.]

7. It is recommended that a special housing initiative be undertaken for children with disabilities in concert with implementation of the Child MH/DD/SAS plans. The growing number of severely disabled children and young people requiring out of home housing in the community, in transition to or from residential settings, should be recognized and supported. In addition, State supported residential and community housing needs still require attention and support. [This has since been implemented in North Carolina.]

Summary of Studies

- Three components are essential in developing supportive housing programs: capital funding, operating subsidy, and support services.
- Supportive housing can, and usually does over time, or nearly can be recovered through the reductions in high cost services (i.e. hospitalization, shelter, prison, jail, etc.) and results in better, higher quality outcomes for those receiving services.
- North Carolina has successfully initiated a number of supportive housing models and has acted on the recommendations of several previous studies. Most notable are the establishment of the Housing 400 and Key initiatives and Oxford House as well as the pilot program to allow the use of Special Assistance (SA) payments to support individuals in community living arrangements.
- There is a need to develop additional housing stock, provide operating assistance and to target that housing for individuals with disabilities.
- There is a continued need to increase incentives for developers to create supportive housing as well as remove barriers in communities (e.g. zoning, housing codes, etc).
- Support services must have significant flexibility to met individual needs.
- Providing supportive housing is almost always less expensive than any other residential response.

In summary the Task Force concluded that:

- Supportive housing promotes greater quality of life, choice, self-sufficiency and community integration.
- Research has demonstrated positive impacts in terms of cost-effectiveness and improvement in quality of life, housing stability and health and behavioral outcomes for people with mental illnesses, developmental disabilities and substance use disorders.
- Even when the costs are comparable between current cycling in and out of crisis care and permanent supportive housing, the greater potential for stability and community inclusion offered by supportive housing make it the better investment for states and communities to make for these vulnerable residents.

Chapter 6. Supportive Housing Cost Analysis

The Task Force identified 1,700 individuals with mental health or substance abuse disorders or developmental disabilities and who are homeless that need supportive housing. To accomplish this goal, the State must employ a variety of models. The models include using capital funding to build new structures or to renovate existing available units in both integrated and stand alone settings based on local and individual needs. They must include operating subsidies to make the housing affordable to individuals who have extremely low incomes (e.g., those on SSI income) and who can receive the necessary services and supports across service agencies and county lines. The strategies defined in this chapter are largely cost neutral, greatly enhancing the benefits the identified individuals receive.

Costs of Supportive Housing Units

The following strategies for housing development programs and tenancy supports present costs separated out by the three components of supportive housing – capital, operating subsidy, and services and supports – and assume a period of three years of development.

The housing development programs overseen by the North Carolina Housing Finance Agency (HFA) described in chapter 4 are currently designed with the necessary flexibility to meet the identified needs from a capital perspective, though the current funding levels are inadequate to develop the units needed as identified in the report.

1) **Housing Tax Credit/Rental Production/Targeting/Key Programs**

The Housing Credit Program by itself, or in conjunction with the NC Housing Finance Agency's Rental Production Program (RPP), creates approximately 35 properties annually statewide, with 2,500 affordable units. This results in about 250 units of housing each year that are targeted to persons with disabilities who have income at SSI income levels. These units are known as Targeted Units. Over a three year period the program would produce a total of 750 Target Units.

Capital: All units are built, managed, and monitored through an existing efficient affordable housing production program, thus there is no

Since 2002, DHHS and NCHFA have partnered in the development of integrated permanent supportive housing through these programs. The Targeting Program has been recognized with two national awards from the national Council of State Housing Agencies and from the National Alliance for the Mentally Ill. The program has also been replicated by housing finance agencies in four states and served as the model for the U.S. Frank Melville Supportive Housing Investment Act of 2010 (S. 1481) that was signed into law January 4, 2011 to modify a portion of the federal 811 program that develops housing for persons with disabilities.
See: http://blog.govdelivery.com/usodep/2011/01/the-frank-melville-supportive-housing-investment-act-of-2010.html

required incremental capital cost to the State for the 750 Targeted Units.

Note: In recent years, Rental Production Program (RPP) funding has been inadequate for the number of strong applications. As a result, higher scoring applications requiring both Housing Credit and RPP funds were not funded, and instead, weaker applications requesting only Housing Credits were funded. RPP uses the Housing Trust Fund (HTF) as a source of funds and additional investment in the HTF would allow for higher scoring applications to be funded. If the investment was increased by $20 million or more, smaller scale (less than 24 units) integrated rental housing that would fit smaller community needs could be created.

Operating Assistance: The DHHS Operating Subsidy funds the Key Program. This is the State-funded, production-based operating subsidy created solely to make apartments affordable to persons with disabilities with income as low as SSI to access housing. It was created in conjunction with the Housing Credit/Rental Production/Targeting Programs and is designed to take advantage of these ongoing and proven affordable housing programs where operating costs are already reduced below market rate, minimizing the amount needed for the Key subsidy. This partnership reduces the gap between what a person on SSI income can affordably pay and the amount needed to properly operate and maintain a property. In addition, Key is designed as a bridge subsidy with the goal to transition tenants to permanent, portable federal assistance, (e.g. Section 8) as soon as it become available.[35] Over the life of the program, Key costs an average of $220 per unit per month when used in conjunction with Housing Credit projects, making Targeting and Key a highly efficient leveraging of resources.

Access to Disability Specific Services: Tenants access services that they need to be successful in their community through normal service delivery channels. Potential tenants are referred to Targeted Units by specifically trained service providers that have become approved referral agencies.

Additional barriers identified are (1) the ability of residents to pay one time rent and utility deposits, and (2) the ability of service providers to be paid for tenancy support activities such as advising on how to be a good neighbor, maintaining an apartment, and budget counseling that focuses on timely rent payments.

Cost Estimates: The ability to continue this program is only limited by access to recurring appropriations for the Key Program, and staff capacity at DHHS and the NC Housing Finance Agency. As additional funded units come on line, the existing staff capacities will be inadequate, necessitating funds for administration. Based upon current values, projected costs for the expansion of the DHHS-NCHFA partnership in these programs are shown in Table 8.

[35] Section 8 administrators receive funding directly from HUD and the State does not control access to Section 8 waiting lists.

Table 8. Projected Costs for Expansion of Housing Tax Credit/RPP/Key Program

Funding	**Expense Calculation**	**Total Cost to State**
Housing Tax Credit/RPP	[paid by existing housing production programs]	$0
Deposit assistance	$750 per unit multiplied by 750 units	$562,500
	TOTAL Non-Recurring	**$562,500**
Key Program recurring	$220 per unit multiplied by 750 units multiplied by 12 months	$1,980,000
Key Program recurring administration	7.5% of Key Program funding	$148,500
	TOTAL Annual Recurring	**$2,128,500**

2) <u>Supportive Housing Development Program</u>

The Supportive Housing Development Program (SHDP) provides no-interest loans of up to $600,000 per development of emergency, transitional and permanent housing. This program would be appropriate to address the one to six month transitional services needed to stabilize some anticipated program participants when first discharged from institutional care.

The 400 Initiative, as discussed in chapter 4, offered additional options of zero percent (0%) interest construction lending and permanent financing for up to a 100 percent of the cost of the project (only needed when no local funds were available), or $1.2 million, which ever was less. This opportunity was discontinued when the 400 Initiative went unfunded in fiscal year 2010.

<u>Capital</u>: The current portfolio of the Supportive Housing Development Program shows that the cost of small-scale independent rental developments varies widely. Among other factors, zoning, housing style, regulatory requirements, durability of materials and geography result in a significant fluctuation of costs. In addition, SHDP development has minimal economies of scale for fixed costs because these are spread over 12 or fewer units, in comparison to Housing Credit projects which usually have 40 or more units. As a result, per unit costs range from a low of $100,000 per unit to a high of $200,000. Based on historical production, 180 units could be funded using both the standard SHDP and the 400 Initiative version of SHDP over three years.

<u>Operating Assistance</u>: As described above, the Key Program is the State-funded production-based operating subsidy that covers the gap between what extremely-low-income residents can afford to pay and a statewide payment standard set to provide what the property needs to operate the unit. As with Housing Credit properties, Key is designed as a bridge subsidy and requires that all participants be actively on Section 8 waiting lists if the local Section 8 administrator is taking applications. However, unlike Housing Credit properties, small supportive housing properties need a higher operating payment standard because they are not mixed income properties and lack higher-income tenants to help defray operating costs. These Key costs are estimated at $250 per unit per month.

Access to Disability Specific Services: Tenants access services that they need to be successful in their community through normal delivery channels. In some supportive housing properties the sponsor or owner may provide additional site-based supportive services. Service providers are limited in their ability to be paid for tenancy support activities such as support for improving relationships with neighbors, maintaining a clean and safe apartment, and budgeting for timely rent payments. It should be noted, however, that no tenant is able to access the Key Program without being linked with a provider committed to assisting the tenant, at a minimum, with disability specific service needs.

As described above the residents are limited in their ability to pay one time rent and utility deposits.

Cost Estimates: The cost estimates assume developing half of the 180 units under the 400 Initiative version of SHDP to promote faster and more flexible development at $150,000 per unit. The other 90 units, following current guidelines, would receive a maximum investment of $60,000, thus reducing State construction costs per unit. In addition, Key Program operating subsidies are essential to make these units affordable to extremely-low-income persons with disabilities.

Table 9. **Projected Costs for Expansion of the SHDP – 400 Initiative**

Funding	**Expense Calculation**	**Total Cost to State**
Capital from SHDP	90 units multiplied by $150,000 = $13,500,000 plus Other 90 units multiplied by $60,000 = $5,400,000	$18,900,000
Deposit assistance	$750 per unit multiplied by 180 units	$135,000
	TOTAL Non-Recurring	**$19,035,000**
Key Program recurring	$250 per unit multiplied by 180 units multiplied by 12 months	$540,000
Key Program recurring administration	7.5% of Key Program funding	$40,500
	TOTAL Annual Recurring	**$580,500**

3) North Carolina's Oxford House Partnership Program

Recognized as a national best practice model for effectively promoting long-term abstinence, Oxford House is a cost effective model that can be readily replicated statewide. Since 1990, the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Service has supported the development of Oxford Houses through a revolving loan program that currently utilizes $350,000 of recurring State appropriations and federal Substance Abuse Prevention and Treatment Block Grant funds that funds Outreach Workers to establish six new recovery houses.

Capital: Expanding this program involves no capital investment since it leases existing housing stock.

Operating Assistance: Requires no operating subsidy because the residents pay rent that covers all housing costs.

Access to Disability Specific Services: Oxford Houses are peer-operated with residents receiving support they need from peers facing the same issues. The program includes mentoring and assistance in community services to support recovery. The access to community services would likely need to be expanded for the anticipated program participants, requiring a variation of the standard Oxford House model. Funding is needed for additional Oxford House Outreach Workers and an infusion to the revolving loan program.

Cost Estimates:[36] To support 60 new houses serving an average of six persons per house or approximately 360 additional people over a three year period, funding for 15 Outreach Workers is needed plus $200,000 in revolving loan funds. The $75,000 is estimated to include salary, benefits, travel, training and administrative expenses.

Table 10. Projected Costs for Expansion of the Oxford House Partnership Program

Funding	**Expense Calculation**	**Total Cost to State**
No Capital	Utilizes existing housing	$0
Revolving Loan Funds	One-time addition	$200,000
	TOTAL Non-Recurring	**$200,000**
No Operating Assistance	Residents pay rent and all housing costs	$0
Recurring Support for 15 new Oxford House Outreach Workers	15 positions multiplied by $75,000 (salary, benefits, travel, etc.)	$1,125,000
	TOTAL Annual Recurring	**$1,125,000**

[36] This section may change to accommodate a lower average household size in conjunction with pilot houses that focus on mental illness only.

4) Tenant-Based Rental Assistance Program (TBRA)

Many states supplement the shrinking supply of federal assistance with a state-funded tenant-based rental assistance program, often administered by the human service system. Like the federal Section 8 Voucher program, TBRA allows consumers to rent units in the market where tenants pay a share of their income toward rent and the assistance makes up the difference in the cost of the unit.

Currently, the State of North Carolina does not fund a tenant-based rental assistance program. The program envisioned is one that could serve high-priority, high-cost consumers with the highest barriers to housing. This is ideally suited to the anticipated program participants addressed in this report and addresses local conditions that the other programs cannot. Local management entities (LMEs) and Public Housing Authorities have experience working together using federally funded TBRA subsidies through the administration of over 1,000 McKinney-Vento Shelter Plus Care Vouchers and this experience could be leveraged when implementing a State TBRA program.

Capital: No capital investment is needed since TBRA accesses existing housing stock.

Operating Assistance: The rental assistance would cover the gap between what extremely-low-income residents can afford to pay and the rental costs of a modest, private unit, limited to the Fair Market Rent in a given area.[37]

Access to Disability Specific Services: It is critical to the success of the TBRA program designed to serve high-risk consumers that recipients of the rent assistance be closely linked with the most intense services and supports available in the community. Care coordination through the LMEs will ensure that residents receive what they need to maintain their housing.

Cost Estimates: Estimating the cost of a TBRA program must include the possibility that recipients could be either individuals who have not yet accessed disability benefits or individuals in recovery who may be ineligible for SSI and consequently may have no income or savings. Therefore, estimates exclude any contribution from the recipient and are based on a statewide Fair Market Rate and one-time deposits for rent and utilities.

With the increased flexibility of a TBRA program comes increased State and local administration that is labor intensive. Local administrative functions include developing a landlord base, executing assistance agreements, processing tenant applications, calculating rental share, inspecting units, processing payments, etc. The costs of providing 420 units of tenant based rental assistance are shown in Table 11.

[37] Fair Market Rates are set annually by HUD based upon the 40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers and estimated utility costs in a particular local housing market.

Table 11. Projected Costs for Tenant-Based Rental Assistance Program (TBRA)

Funding	**Expense Calculation**	**Total Cost to State**
No Capital	Utilizes existing housing	$0
Deposit assistance funding	$750 per unit multiplied by 420 units	$315,000
	TOTAL Non-Recurring	**$315,000**
TBRA recurring	$681 per unit multiplied by 420 units multiplied by 12 months	$3,432,240
TBRA annual recurring administration	10% of TBRA funding	$343,224
	TOTAL Annual Recurring	**$3,775,464**

5) Access Points for Services (e.g. Help Centers, Onsite Service Professionals)

In many of the successful models outlined in Chapter 3 timely access to services and supports made the difference. In one case there was a help center that supported many individuals across a scattered site apartment complex, in another there was one full time service professional that supported a standalone supportive housing development, and in yet another there was a part time service professional supporting individuals living in scatter sites across a county. In all cases these professionals provided a bridge for individuals transitioning from homelessness or institutionalization by ensuring that the individual accessed individualized community-based service providers and tenancy supports.

Capital: No capital investment is needed since service is coordinating individuals in existing housing.

Operating Assistance: No operating assistance for housing is needed, as this service coordinates individuals in existing housing with appropriate operating assistance that is already in place.

Access to Disability Specific Services: It is critical to the success of a supportive housing program designed to serve high-risk consumers that recipients be closely linked with the most intense services and supports available in the community. Care coordination through the LMEs will ensure that residents receive what they need to maintain their housing. This service can enhance disability specific services by ensuring they are being quickly and consistently accessed and that tenancy supports are in place to deescalate tenancy issues from becoming health crisis issues.

Cost Estimates: Flexibly fund 10 pilot projects to assist 10 supportive housing projects or catchment areas to demonstrate effectiveness.

Table 12. **Projected Costs for Service Access Points**

Funding	Expense Calculation	Total Cost to State
No Capital	Uses existing housing	$0
	TOTAL Non-Recurring	**$0**
No Operating Assistance	Stabilization services to those accessing housing or already in housing.	$0
10 pilot projects recurring costs	10 pilot projects estimated at costing $250,000. (10 pilot projects multiplied by $250,000.)	$2,500,000
	TOTAL Annual Recurring	**$2,500,000**

Additional Strategies to Improve Supportive Housing Outcomes

1) SSI/SSDI Outreach, Access and Recovery, known as SOAR

A comprehensive overview of costs must include the percentage of costs that are likely to be paid by federal sources, especially the federal portion of Medicaid. To bring down State costs, it is imperative that the anticipated program participants access Medicaid to the maximum extent possible.

As noted above, the anticipated program participants identified in this report are primarily persons with mental health or substance abuse disorders who are also homeless. The Social Security Administration identifies that only 15% of all homeless people who apply for disability benefits are approved at their first request and homeless persons with mental illness have a smaller rate of approval.

SOAR, SSI/SSDI Outreach, Access and Recovery, is a specific strategy used to assist first time applicants in the disability process. In North Carolina, there are 11.5 Full Time Equivalent staff who work exclusively with SOAR. In addition, some community have non-dedicated staff that occasionally assist applicants using the SOAR methodology. Most SOAR workers are hired by nonprofits. These workers have a 77% success rate for 244 first-time homeless disability applicants. Each person approved for SSI is automatically eligible for Medicaid. In addition, since June 2, 2010, these successful applicants have brought $1,141,813 in cash benefits into the State. These cash benefits can be used, in part, to pay towards housing costs, reducing the monthly rental assistance required to assist those successful applicants.

Thus, an investment in dedicated SOAR workers focusing on this population would result in ongoing reduced State burden for services costs, and ongoing reduced State rental assistance and operating costs for supportive housing units.

Each LME and each State psychiatric hospital should have a dedicated SOAR worker.

Capital: No capital investment is needed, as this service qualifies individuals for SSI/SSDI to allow them to access existing housing.

Operating Assistance: No operating assistance for housing is needed, as this service qualifies individuals for SSI/SSDI to allow them to access existing housing assistance programs. In addition, successful applicants are able to pay a portion of their rent themselves, reducing public operating assistance costs.

Access to Disability Specific Services: Since persons receiving SSI are automatically qualified for Medicaid, SOAR results in improved access to services for any beneficiary.

Cost Estimates: A total of 26 SOAR positions are needed: one located at each of the 23 LMEs and at each of the three psychiatric hospitals. These costs are quickly offset by federal cash assistance brought into the State as well as increases in access to Medicaid-funded supports.

Table 13. Projected Costs for SOAR

Funding	**Expense Calculation**	**Total Cost to State**
SOAR recurring administration	26 SOAR workers (one for each LME and one for each hospital) multiplied by $75,000 (salary, benefits, travel, etc.)	$1,950,000
	TOTAL Annual Recurring	**$1,950,000**

2) NCHousingSearch.org

The NC Housing Search website is completely free to landlords and consumers. The website is bilingual and provides listings of affordable rental housing currently available in North Carolina. These listings provide extensive information on accessibility features of all units. The site has become a major resource for those in need of affordable housing or units with special features, public and nonprofit human services agencies, and landlords in marketing their properties. Only currently available units appear in a web search. Through the password protected access point, case managers can locate housing willing to take difficult to place populations. There is a Special Needs Housing Search Tool component that allows servicers with access to this restricted area to connect with property providers who have indicated a willingness to promote units to selected special needs populations. It is recommended that this restricted access be given to staff whose job descriptions directly correlate to researching, locating, and securing housing for their clients on a regular basis, and a State level position is needed to coordinate that restricted access.

As mentioned in chapters 2 and 3, this service would be used to track housing options for anticipated program participants, and to document any difficulties in housing opportunities that cross LME or county lines.

The site is operated by Socialserve.com, a nonprofit technology solution provider headquartered in Charlotte, NC. Socialserve has a track record of building and maintaining affordable housing locators across the country. They currently operate sites in twenty states, and all these websites can be accessed directly from the national Socialserve.com site. The estimated annual costs of operating the site are $200,000 and $75,000 for the State level staff (salary, benefits and travel).

Capital: No capital investment is needed since using an existing software system making access to existing housing stock easier.

Operating Assistance: No operating assistance for housing is needed, as this service allows individuals and service providers to find appropriate housing more quickly. The website also notates what kind of rent assistance is accepted.

Access to Disability Specific Services: It is critical to the success of individuals to find appropriate housing as quickly as possible to allow them: 1) to receive services and 2) to receive greater benefits from the services than if the individuals were in an unstable housing environment. The password protected feature allows service providers to maintain other non-public information about housing that is not available anywhere else to allow better decisions to be made about available housing. Care coordination through the LMEs will ensure that residents receive services needed to maintain their housing.

Cost Estimates: Fund annual operating costs and fund one position to administer password protected areas and train service providers on how to use tool.

Table 14. Projected Costs for NCHousingSearch.org

Funding	Expense Calculation	Total Cost to State
NCHousingSearch recurring operational costs	Annual operational cost for service including software updates, custom reporting, and bi-lingual call center.	$200,000
NCHousingSeach recurring administration	One position to administer password protected area and provide training to service providers. (Multiplied by $75,000 (salary, benefits, travel, etc.)	$75,000
	TOTAL Annual Recurring	**$275,000**

Costs of Services and Supports

The Task Force assumes that majority of adult consumers would be eligible for, though not necessarily receiving, Supplemental Security Income (SSI) and for Medicaid. Therefore, a variety of Medicaid services would be available depending on the particular needs of each individual.

The report assumes that the following Medicaid-funded services are used most often by all recipients: medication management, peer support, targeted case management and either community support team (CST) or assertive community treatment team (ACTT).

Other Medicaid services and supports in addition to crisis services include personal care (PC), psychosocial rehabilitation (PSR), partial hospitalization (PH), substance abuse outpatient programs and detoxification programs.

To gain access to the Key operating subsidy program described above, an individual must be referred by a service provider approved by DHHS and NCHFA as a referral agency.[38] The referral agency must have trained staff, provide services and supports and commit to support the individual for the long term. Staff develop the individual's person centered plan and crisis plan and ensure an individual's access to federal entitlements such as Medicaid and SSI as well as various services and community supports, in addition to referring the individual as an applicant for housing.

Tenancy supports are individualized and may be tied to a disability. They frequently keep a tenancy crisis from developing into a disability crisis, such as negotiations with the landlord, education regarding tenant and landlord rights and responsibilities, and crises involving lease violations.

State funding is needed for the coordination and administration of such developments and of the transition of individuals leaving hospitals or correctional institutions, and staffing of the 24/7 help center, and for providing tenancy supports.

Factors Influencing Costs

In recent years supportive housing programs for the homeless mentally ill population have been increasingly likely to track and publish data about program costs. As a result of those publications, several key factors related to project costs for the anticipated program participants have been identified, which are cited below.

- Upon initial occupancy of a permanent housing unit, the tenant is likely to begin accessing general health care service at an increased rate. These costs are usually connected to chronic health conditions such as diabetes and hypertension as well as physical conditions that homeless persons are more vulnerable than the general population. However, by year five of tenancy, (year three in most cases), medical costs significantly reduce. The cost analysis below only projects costs for three years, and thus does not include the significant medical savings that appear after that three year mark.
- Upon stabilization in permanent housing, the second most common services request, behind medical care, is assistance with employment. While not all of the anticipated program participants would be able to successfully engage employment, a significant percentage would and will, resulting in the tenants' ability to assist in paying for services and housing costs, further offsetting State costs.

[38] This process is agreed between NCHFA and DHHS.

- Using SOAR workers, almost all tenants will be able to access disability payments and Medicaid, resulting in the tenant's ability to assist in paying for services and housing costs. Intentionally hiring SOAR workers early in the process will maximize Medicaid access as well as aggregate dollars available to program participants to cover their own expenses. The earlier SOAR workers are hired, the greater the net cost savings to the State.

This report does not take the above documented trends into account. Therefore, it is reasonable to expect that actual costs will be less, and the cost off-sets will be greater.

Summary of Costs

Table 15 provides the summary of supportive housing costs that reflect only the State portion of funding needed to implement the above strategies and provide 1,700 individuals with mental health or substance abuse disorders or developmental disabilities who are homeless with needed supportive housing and related services.

Potential Cost Offsets

Successful programs in North Carolina and other states have demonstrated that utilization of and readmissions to State psychiatric hospitals are reduced when transitional and permanent supportive housing are included in community services and supports for individuals with mental illness, substance abuse, and developmental disabilities.

As described in chapter 3, services, supports and administration of Bridges of Hope operated on $250,000 per year while supporting 15 to 20 individuals with staffing of the program and the 24/7 Help Center and saved the State the total costs of incarceration and re-hospitalization for these individuals. Housing, rental subsidies and Medicaid provided the remaining financial support. Previous costs to the State for these individuals from public records, judicial records, hospital records had exceeded $1 million total.

A cost analysis conducted in 2007 of the Lennox Chase complex (described in chapter 3) calculated an overall cost reduction of 29.53 percent for 21 residents including the cost of an on-site social worker. Although the cost of medical treatment almost doubled for two residents, the cost of inpatient substance abuse treatment fell 100 percent, the cost of outpatient mental health services fell 95 percent, and the cost of incarceration fell 100 percent. The overall savings for the 21 individuals who lived in the complex for two years or more was about $111,357 compared to the two years prior to entering the complex. This is approximately a savings of $5,303 per individual over two years or $2,652 per year. This includes the cost of administration and an on-site social worker to provide tenancy support of $54,835 over two years. This also includes 100 percent of the medical costs that are estimated to be 80 percent covered from Medicaid. Table 16 reflects the state cost of 20 percent medical expenses resulting in a greater savings to the state.

Table 15. Cost Summary of Recommended Housing Programs

Program	# Units	Capital & Deposits (non-recurring)	Recurring Operating Subsidies (includes administration)	Recurring Services	Notes
Housing Tax Credit / Rental Production Program (RPP) / Targeting / Key Program	750	$562,500	$2,128,500	$0	Increased Housing Trust Fund appropriations would increase the quality of units available and promote smaller unit properties in smaller communities. This also requires increases in the DHHS Operating Subsidy (Key Program).
Supportive Housing Development (SHDP) / Key Programs	180	$18,900,000 $135,000	$580,500	$0	Increased Housing Trust Fund appropriations could restart progress made under the Housing 400 Initiative. This would need to be accompanied with increases in the DHHS Operating Subsidy (Key Program)
North Carolina's Oxford House	360	$200,000	$0	$1,125,000	Provides an environment that responds to the unique needs of substance abuse recovery.
Tenant-Based Rental Assistance	420	$315,000	$3,775,464	$0	Provides the most flexible community tool.
Service Access Points	0	$0	$0	$2,500,000	Allows for 10 pilot programs flexible funding to support clients to successfully stay in housing by providing tenancy supports and necessary connections to clients' individual service providers.
TOTALS	**1710**	**$20,112,500**	**$6,484,464**	**$3,625,000**	

Table 16. Lennox Chase Two Year Cost Analysis

Cost for 21 persons for two years	Cost of Housing	Cost of Inpatient Hospitali - zation	Cost of Outpatient Mental Health Services	Cost of Physical Health Treat- ment	Cost of Prison / Jail	Total
Before moving to Lennox Chase	$7,504 (Shelter only)	$42,500 (psychiatric hospital) $127,721 (SA treatment)	$85,381	$22,110	$3,486	$288,702 ($13,748 per person)
After moving into Lennox Chase	$54,835 (with on-site social worker)	$5,346	$4,000	$40,321	0	$104,502 ($4,976 per person)
Cost Savings	-$47,331	$37,154 + $127,721 = $164,875	$81,381	$18,211	$3,486	$184,200 ($8,771 per person)

Using Lennox Chase as an example (given the extensive cost analysis) a savings over two years for 1,700 people could be quite extensive for the State. Assuming all 1,700 are involved in some combination of cycling in and out of psychiatric hospital care, incarceration, and/or use of the emergency departments within the two years prior to entering a supportive housing situation, there is the potential savings to the State of $4,386 per year for each individual.[39] For 1,710 individuals this is a total savings of $7,500,060 per year.

When these projected annual savings due to reduced utilization of institutions (shown in Table 16) is subtracted from the projected recurring costs for operating assistance and services (shown in table 15), the net difference is about $2,600,000. This amount would likely be significantly, if not totally, offset by investing in the SOAR strategy early during project implementation as presented above.

Table 17. Projected Annual Savings

Recurring Costs Operating Assistance	$6,484,464
Recurring Service Costs	$3,625,000
Total Recurring Costs	**$10,109,464**
Less Annual Cycle Savings	($7,500,060)
Annual Net Difference	**$2,609,404**

[39] Not all Lennox Chase residents would have fallen into the anticipated program participant population. Therefore, not all of these residents had the higher pre-housing costs, such as state hospitalization costs, that would be expected for this program. Therefore, actual cost savings are likely to be higher than seen in the following chart.

Conclusion

The cost analysis outlined in Table 16 show that an effective intervention resulting in lower rates of hospitalization can be achieved with no additional costs to the State. Furthermore, the opportunity for significant cost savings is very real, and will increase the longer participants have had access to permanent supportive housing. Through early investments in ensuring access to disability and Medicaid, the State can increase the likelihood and amount of cost savings.

Chapter 7. Recommendations

As demonstrated in this report, the Task Force has come to a firm agreement that providing supportive housing and services for individuals with mental health and substance abuse disorders or developmental disability dramatically improves their quality of life and is more cost effective than allowing these individuals to cycle in and out of psychiatric hospitalization, crisis services, jail, prison and homelessness. Services and treatment are demonstrated to be more effective if an individual has a stable, safe place to live and supports to remain at home. Essential elements must be in place for supportive housing for this population to be successful.

The legislation requires the Task Force to use information gathered about the frequent users of psychiatric beds and emergency departments to:

- Develop a business case for the development of a statewide supportive housing initiative to benefit MH/DD/SA populations.
- Calculate the number of housing units needed statewide.
- Calculate the level of capital investment needed for a multi-year initiative.
- Propose different methods that could be used to pay ongoing operational costs.
- Examine potential cost-savings of the strategy.

The preceding chapters as summarized below build the case for a statewide supportive housing plan to meet the needs of individuals with mental health and substance abuse disorders or developmental disabilities and to obtain maximum cost savings for the State of North Carolina as a whole.

As a result, the Task Force recommends strategies that will provide supportive housing for 1,700 individuals over a period of three years becomes cost neutral to the State while improving the quality of life for these vulnerable residents. Further, this approach will lay the groundwork for a statewide system for moving from institutional care to integrated community care.

Chapter 1 defines supportive housing as affordable housing connected with services and supports. This includes both transitional and permanent supportive housing models. All models need three elements for successful creation and on-going operation: capital funding, operating subsidy, and necessary services and supports.

Chapter 2 presents available data about individuals who are frequent users of State psychiatric hospitals, emergency departments, crisis services and jails/prisons. The Task Force found that these individuals with mental health or substance abuse disorders and who are also homeless frequently cycle in and out of all of these services. Furthermore, their homelessness creates barriers for them to take advantages of housing and community mental health, developmental disabilities, and substance abuse services and supports.

The Task Force concluded that approximately 1,700 adult individuals currently need supportive housing that is not currently available and that LMEs/community service providers can identify the individuals as the anticipated program participants.

Chapter 3 and 4 outlined successful models currently in use and the funding streams that are available while chapter 5 presented outcomes from previous studies. Chapter 6 provides an analysis of costs for implementing various strategies.

This chapter presents the recommendations of the Task Force in response to legislation and at the request of the Secretary of the Department of Health and Human Services. The Task Force recommends that the State take action based on the strategies described below and greater detail in the chapters of this report. A summary of the costs associated with the recommendations is provided in Table 18.

Recommendation 1. The Task Force recommends that the State provide permanent supportive housing for 1,700 individuals with mental health or substance abuse disorders or developmental disabilities who are homeless and frequent users of psychiatric hospitalization, crisis services, jail or prison. This will be accomplished by expanding existing housing programs and supportive programs that are successfully administered in North Carolina to create permanent homes and improved access to services and supports and to lay the ground work for a statewide system for moving from institutional care to integrated community care.

Strategy 1.1 Increase the State's ability to identify and qualify individuals for SSI/SSDI at the local level thereby increasing individual's income and access to Medicaid and reducing use of State resources, by funding 26 dedicated SOAR positions with one at each of the 23 LMEs and each of the three State psychiatric hospitals at an estimated cost of $1,950,000.

Strategy 1.2 Support the enrollment of potential Medicaid recipients prior to January 2014 to increase access to current benefits.

Strategy 1.3 Support the partnership of DHHS and NCHFA to provide 1,700 additional supportive housing units by:

- Increase funding by $2,709,000 for the DHHS Operating Subsidy to continue the Key Program and allowing administrative costs for up to 7.5% of funding.
- Expand funding of $3,775,464 through DHHS Operating Subsidy to create a Tenant Based Rental Assistance Program and allowing administrative costs for up to 10% of funding.
- Expand funding of $1,012,500 through DHHS Operating Subsidy to create a Deposit Program to allow for up-front rental and utility deposits to be paid reducing a primary barrier in obtaining housing.

- Expand Oxford Houses Partnership Program by funding it with a one-time addition of $200,000 to the revolving loan program and 15 positions at an estimated cost of $1,125,000.
- Increase funding by $18,900,000 for the Housing Trust Fund.
- Create a source of "bridge funding" to support payment for security deposits, utilities, transportation and other expenses during transition to permanent supportive housing.

Recommendation 2. The Task Force recommends implementation of these expanded housing and supportive programs over a period of three years through 10 pilot programs across the State in a variety of communities.

Strategy 2.1 Fund $2,500,000 to provide flexible funding to the pilot projects to customize necessary services and supports to ensure individuals have transition services they need, maintain access to their individual service providers, and are provided tenancy supports as needed. This includes the provision of Assertive Engagement and 24/7 support needed during the transition period from institution or homelessness to supportive housing.

Strategy 2.2 Ensure staff of supportive housing programs and service providers receives training on tenancy supports, including landlord and employer relationships.

Strategy 2.3 Work to eliminate barriers to access for housing and employment for individuals with mental health or substance abuse disorders that leaving prison or jail.

Strategy 2.4 Promote wraparound services through a system of care approach to facilitate the transition of individuals discharged from institutions to the community services.

Recommendation 3. The Task Force recommends strengthening the State's capacity to implement, oversee and evaluate the effectiveness of permanent supportive housing, services and supports on the quality of life of program participants.

Strategy 3.1 The Practice Improvement Collaborative (PIC) review and recommend models of services and supports that are evidence based or emerging best practice for individuals with mental health or substance abuse disorders and who are homeless.

Strategy 3.2 DHHS consider asking the North Carolina Interagency Council for Coordinating Homeless Programs (ICCHP) to advise and review the work of all participating agencies as these agencies promote supportive housing for individuals with mental health or substance abuse disorders or developmental disabilities in all areas of the State, investigate best practices, sponsor pilot projects, provide oversight, conduct performance evaluation and secure funding and technical assistance for local supportive housing projects.

Strategy 3.3 DHHS develop a clearinghouse of housing resources across the State in the Office of Housing and Homelessness by expanding the NCHousingSearch.org tool. This strategy increases the State's ability to track and access supportive housing for all disabilities and special needs by funding NCHousingSeach.org and a dedicated position within the DHHS Office of Housing and Homelessness to administer access to restricted areas and to train housing and service providers on its use at an estimated cost of $275,000.

Strategy 3.4 Fund one position within the DHHS Office of Housing and Homelessness that is responsible for tracking program participants to ensuring they receive housing and service resources necessary for remaining in the community and for evaluating the success of the pilot programs in terms of improving the quality of life, enhanced effectiveness of services provided, and the cost effectiveness of providing housing, tenancy and SOAR services at an estimated cost of $75,000.

Strategy 3.5 Ensure coordination among LMEs, service providers, housing, and Community Care of North Carolina to assure physical healthcare access for program participants.

Strategy 3.6 Provide technical assistance to communities statewide for leveraging funding and accessing resources available to develop and finance supportive housing options locally.

Strategy 3.7 Develop coordination among information technology systems that supports sharing of information and tracking individuals across systems and services including Medicaid, IPRS, HEARTS, CCNC, CHIN, prisons and jails, and enables LMEs to coordinate care and maximize the use of limited funds.

Table 18. Summary of Costs to the State Based on the Recommendations

Recommendation / Strategy	One-Time Costs	Annual Recurring Expense
Strategy 1.1 Fund SOAR Workers		$ 1,950,000
Strategy 1.3 Increase Key Funding for LIHTC targeted units and SHDP Program		$ 2,709,000
Strategy 1.3 Tenant Based Rental Assistance Program including administrative support		$3,775,464
Strategy 1.3 Create Deposit Program	$ 1,012,500	
Strategy 1.3 Oxford Style Peer Housing Programs	$ 200,000	$ 1,125,000
Strategy 1.3 Housing Trust Fund	$18,900,000	
Strategy 2.1 Pilot Service Projects		$ 2,500,000
Strategy 3.3 Expand NCHousingSearch.org		$ 275,000
Strategy 3.4 Staff position to track anticipated program participants		$ 75,000

Clearly, this is the time and opportunity to take action to continue North Carolina's success and leadership in responding to individuals with mental health or substance abuse disorders or developmental disabilities and who are homeless through the provision of permanent supportive housing. Although the costs and cost offsets of these strategies will involve some ongoing funding each year, these costs can be minimized by increasing the eligibility of these individuals' entitlement to Medicaid and Supplemental Security Income.

The recommendations and strategies will enable the State to provide permanent supportive housing and greatly enhance the lives of 1,700 individuals with mental health or substance abuse disorders or developmental disabilities and relieve the State of crisis services for that high cost group of people. Further research and planning will determine the success of the demonstration pilot projects and develop the means to reinforce the viability of community-based services.

References

North Carolina Studies

The North Carolina Institute of Medicine Task Force on Long-Term Care, A Long-Term Care Plan For North Carolina: Final Report, 2001

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Estimated Cost Savings Following Enrollment in the Community Engagement Program: Findings from A Pilot Study of Homeless Dually Diagnosed Adults, May 2006. Thomas L. Moore, PhD. Retrieved from http://www.shnny.org/documents/CEPCOST-BENEFITlinktoCEP_000.pdf

For the NY City info & Chart Report of Nine Cities: Supportive Housing for People with Mental Illness: Regaining a Life in the Community, September 25, 2007. The Webcast was funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services through a contract to JBS International, Inc., and was developed in collaboration with the National Association of State Mental Health Program. http://www.dhmh.maryland.gov/mt/pdfs/Reference%20-%20Transformation%20-%20Supportive%20Housing.pdf

Other References

SAMHSA Services in Supportive Housing
http://homeless.samhsa.gov/ssh/index.aspx

SAMHSA provides a variety of documents to assist in development and management of PSH on topics such as evaluating a program, training staff, training consumers, getting

started, building your program, using multimedia, and resources for training and education.
http://homeless.samhsa.gov/ssh/documents.aspx?folder=Permanent%20Supportive%20Housing&mode=&search=&filter=&fd=down

A free statewide listing of rental properties used by renters and agencies to find housing and by property owners/manager to market housing that identifies special features of each property. In addition, there is a secured area for human services information and other information not available to public.
www.NCHousingSearch.org

Terminology

The Assertive Community Treatment Team – ACT is an evidence based practice provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days a week, and 365 days a year, and is prepared to carry out a full range of treatment functions wherever and whenever needed. ACT has been extensively researched and evaluated and has proven clinical and cost effectiveness. The Schizophrenia Patient Outcomes Research Team (PORT) has identified ACT as an effective and underutilized treatment modality for persons with serious mental illness.
http://www.actassociation.org/actModel/

A service recipient is referred to the ACT Team service when it has been determined that his or her needs are so pervasive or unpredictable that they cannot be met effectively by any other combination of available community services. The multi-disciplinary make-up of each team (psychiatrist, nurses, caseworkers, mental health clinicians, vocational rehabilitation specialists, and substance abuse specialists) and the small client to staff ratio, helps the team provide most services with limited referrals to other providers. The Substance Abuse and Mental Health Service Administration (SAMHSA) developed the ACT Tool Kit that offers customized, community-based services for people with mental illness.
http://store.samhsa.gov/product/SMA08-4345

Assertive Engagement is a way of working with adults and/or children who have severe or serious mental illness or substance abuse and who do not effectively engage with treatment services. Assertive engagement is a critical element of the rehabilitation and recovery model as it allows flexibility to meet the consumers' particular needs in their own environment or current location (i.e. hospital, jail, streets, etc.). It is designed as a short-term engagement service targeted to populations or specific consumer circumstances that prevent the individual from fully participating in needed care for a mental health/developmental disabilities/substance abuse services problem.

Continuum of Care Community Plan supported by the U.S. Department of Housing and Urban Development Definition of Continuum of Care: "The Continuum of Care is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness." HUD identifies four necessary parts of a continuum:

- Outreach, intake, and assessment in order to identify service and housing needs and provide a link to the appropriate level of both;
- Emergency shelter to provide an immediate and safe alternative to sleeping on the streets, especially for homeless families with children;
- Transitional housing with supportive services to allow for the development of skills that will be needed once permanently housed;
- Permanent and permanent supportive housing to provide individuals and families with an affordable place to live with services if needed.

There are 12 Continua of Care in North Carolina. The structure of Continua varies amongst our communities. Some cities and counties assign staff to assist the Continuum while other communities ask organizations to volunteer their time. To find updated contact information for the CoC for your area, visit http://www.ncceh.org/coc.

Cost Burden —HUD considers a household "cost burdened" when its gross housing costs, including utility costs, exceed 30% of its gross income. HUD considers a household "severely cost burdened" when its gross housing costs, including utility costs, exceed 50% of its gross income.

Evidence Based Practice - A practice which, based on expert or consensus opinion about available evidence, is expected to produce a specific clinical outcome (measurable change in client status). These practices include Community Support Team (CST), Assertive Community Treatment Team (ACT), Personal Care (PC), Psychosocial Rehabilitation (PSR), Partial Hospitalization (PH), and Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), and four detoxification programs.

Gross Rent - contract rent plus the estimated monthly cost of utilities and fuels, if these are paid by the renter.

Homeless - the term "homeless" or "homeless individual or homeless person" includes:

- An individual who lacks a fixed, regular, and adequate nighttime residence; and
- An individual who has a primary nighttime residence that is:
    - A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
    - An institution that provides a temporary residence for individuals intended to be institutionalized; or
    - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Homeless Shelters – Over 35 North Carolina counties have no homeless shelters, forcing people experiencing homelessness to double up, live in places not suitable for human habitation or to leave their communities.

Household - all related or unrelated individuals whose current residence at the time of the ACS interview is the address in question

Household income - income of the householder and all other individuals 15 years and older in the household, whether they are related to the householder or not.

Income:
Area median income - a statistic generated by the U.S. Department of Housing and Urban Development (HUD) for purposes of determining the eligibility of applicants for certain federal housing programs. HUD determines AMI on an annual basis for each

metropolitan area and non-metropolitan county, making adjustments for household size and other factors.

- **Middle Income –** Reported income not in excess of 120% of Area Median Income
- **Moderate Income** - Reported income not in excess of 95% of Area Median Income
- **Low Income –** Reported income not in excess of 80% of Area Median Income
- **Very Low Income –** Reported income not in excess of 50% of Area Median Income
- **Extremely Low Income –** Reported Income not in excess of 30% of Area Median Income

Median household income - based on the distribution of households and families including those with no income. It is computed on the basis of a standard distribution. Monthly housing costs as a percentage of household income: developed from a distribution of selected monthly owner costs as a percentage of household income for owner-occupied and gross rent as a percentage of household income for renter occupied housing units.

Overcrowding - HUD considers a household "overcrowded" when the ratio of occupants to rooms exceeds 1. HUD considers a household "severely overcrowded" when the ratio of occupants to rooms exceeds 1.5.

Scattered-site housing includes **i**ndividual units dispersed throughout an area; apartments, condos, single-family houses; can be owned or leased; and must conform to local zoning.

Standard Condition - a unit that meets or exceeds HUD's Section 8 quality standards.[40]

Substandard Condition but Suitable for Rehabilitation – a unit that does not meet Section 8 quality standards but could be brought up to those standards for less than the unit's appraised value."

SSI Income – For individuals with income derived solely from Supplemental Security Income, the housing cost picture is most severe.

[40] HUD's Consolidated Planning regulation at Section 91.305 (b) (1) requires the State to define the terms "standard condition" and "substandard condition but suitable for rehabilitation."